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ABSTRACT

This TIP, on the best practice recommendations for the treatment of substance abuse, presents guidelines for ensuring continuity of care as offenders with substance use disorders move from incarceration to the community. Research indicates that treatment gains may be lost if treatment is not continued after the offender is released from incarceration. This TIP is designed to educate and provide information for community service providers on how to meet offender treatment needs in order to overcome the obstacles to a successful transition. It details how members of a transition team can collaborate to help with the transition to the community. Since offenders generally have complex treatment needs, the TIP suggests that case management is an ideal approach. Treatment guidelines specific to populations such as offenders with mental illness, offenders with long-term medical conditions, and sex offenders are also detailed. Appendixes include: "Bibliography," "Instruments," "Resource Panel," and "Field Reviewers." (Contains 14 figures and approximately 100 resource.) (JDM)

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Center for Substance Abuse Treatment

Continuity of Offender Treatment for Substance Use Disorders From Institution to Community

Treatment Improvement Protocol (TIP) Series

30

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Assessments in the Transition Plan

Offenders who receive substance use disorder treatment in jail are at great risk for relapse and return to crime unless they continue treatment after their release. Among the most important elements of a successful transition are assessments of substance use as well as other areas of the offender's life. Assessments should employ standardized, comprehensive risk and need assessment tools appropriate to offender populations. Assessments for offenders should be conducted within the institution as early and often as possible and also 3-6 months before the offender's release.

Multiple assessments of substance-using offenders are necessary and should examine

- Treatment needs
- Treatment readiness
- Treatment planning
- Treatment progress
- Treatment outcome

Risk and needs assessments are ideally conducted by a multidisciplinary team, with cooperation among all players. Areas to be assessed include skills for daily living, stress management skills, general psychosocial skills, emotional readiness for the transition, literacy, money management abilities, vocational skills, and the family environment to which the offender is returning. Criminal justice staff can contribute critical information on risk of relapse and the offender's dangerousness to others. Assessment results should follow the offender through the system(s).

Family

To the extent the offender's family (which includes significant others) agrees to participate, a prerelease assessment of the family environment should be conducted. This assessment should measure

- Whether other family members have substance use disorders
- Whether there is domestic violence
- Criminal activity of other people living in the house
- The level of support for sobriety
- Hopes regarding family reunification
- Current child care and child custody status
- Those who have been occupying nurturing roles
- The family services already in place
- Areas of potential vulnerability

Prisons, jails, and other incarcerating institutions must work together with community substance use disorder treatment providers to set up and maintain transitional services. This will be a new endeavor for many of the representatives of both systems, and evaluation is essential to the success of the transition. Below are guidelines for how to conduct an outcome evaluation and a process evaluation.

Outcome evaluation determines the effectiveness of a program when comparing the group receiving services to a control group receiving no treatment, an alternative program, or standard treatment. Outcome evaluation measures a program's ability to produce expected changes in the clients who are part of the program. Questions to be asked when conducting an outcome evaluation include

- Do the transitional services reduce relapse and recidivism among offenders?
- What are the relapse and recidivism rates of offenders?
- Do the transitional services assist offenders in successfully reintegrating into the community?
- Do the transitional services help offenders improve their housing, financial, and employment status?
- Do the transitional services assist offenders in accessing other necessary services, such as primary medical and mental health services?
- Are there differences in offender outcome by participation in different services/program components?
- Which program components are associated with positive outcomes?
- Based on client profiles, which clients received the most benefit from transitional services?

Process evaluation examines the implementation procedures and operations of a transitional services program as it compares with the program's stated goals and objectives. Process evaluation can be used to determine whether the people studied actually received program services and measures the intensity and duration of services provided. Questions to be asked when conducting a process evaluation include

- What services have been provided and by which agency?
- How often were services provided?
- Who received services?
- Was the program implemented as designed?
- What are the program's strengths and weaknesses?
- Was the program changed, and if so, how and why?
- What were the catalysts for the changes made?
- How much did the program cost?
- What were the barriers to implementation?

Continuity of Offender Treatment for Substance Use Disorders From Institution to Community

Treatment Improvement Protocol (TIP) Series

30

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The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT, SAMHSA, or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance use disorders, provided as a service of the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance use disorder treatment facilities as substance use disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance use disorder experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance use disorder treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://text.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so that they continue to provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance use disorder treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Continuity of Offender Treatment for Substance Use Disorders from Institution to Community*, spotlights the important moment in recovery when an offender who has received substance use disorder treatment while incarcerated is released into the community. The TIP provides those who work in the criminal justice system and in community-based treatment programs with guidelines for ensuring continuity of care for the offender client.

Treatment providers must collaborate with parole officers and others who supervise released offenders. The TIP explains how these and other members of a transition team can share records, develop sanctions, and coordinate relapse prevention so that treatment gains made "inside" are not lost.

Offenders generally have more severe and complex treatment needs than many substance use disorder treatment clients, which makes case management an ideal approach. The TIP devotes a chapter to ancillary services such as housing and employment. These needs must be addressed if the client is to remain sober. Finally, the TIP presents treatment guidelines specific to populations such as offenders with mental illness, offenders with long-term medical conditions, and sex offenders. Appendixes include assessment instruments and a sample transition plan. This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve substance use disorder treatment in the United States.

Other TIPs may be ordered by contacting SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses its particular areas of expertise until it reaches a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance use disorder treatment field.

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Executive Summary and Recommendations

It is clearly in the public interest for offenders with substance use disorders to receive appropriate treatment both in prison or jail and in the community after release. Numerous studies show that those who remain dependent on substances are much more likely to return to criminal activity. Research also indicates that treatment gains may be lost if treatment is not continued after the offender is released from prison or jail. In part, this is because release presents offenders with a difficult transition from the structured environment of the prison or jail. Many prisoners after release have no place to live, no job, and no family or social supports. They often lack the knowledge and skills to access available resources for adjustment to life on the outside, all factors that significantly increase the risk of relapse and recidivism.

This TIP presents guidelines for ensuring continuity of care as offenders with substance use disorders move from incarceration to the community. The guidelines are for treatment providers in prisons, jails, community corrections, and other institutions, as well as community providers. The following recommendations are based on a combination of research and the clinical experience of the Consensus Panel that developed this TIP. Recommendations based on research are denoted with a (1); those based on experience are followed by a (2). Citations supporting the former appear in Chapters 1 through 6. References to specific programs appear throughout those chapters as well; Appendix B provides contact information for many of those model programs.

Improving Transition to The Community

Much of the responsibility for offenders moving from incarceration to the community lies with community supervision agencies, known in many jurisdictions as parole or postprison supervision. To reach the levels of system collaboration and services integration required, staffs from criminal and juvenile justice supervision and substance use disorder treatment agencies must reach beyond traditional roles and service boundaries by brokering services across systems, sharing information, and facilitating the treatment process. (2)

Overcoming Obstacles to Successful Transitions

Obstacles to successful transition include the fragmented criminal justice system, the lack of attention to offender issues by community treatment providers, disjointed (or nonexistent) funding streams, and the varying lengths of sentences. The following will help overcome those obstacles:

- Fostering criminal and juvenile justice systems integration (for example, CSAT's Juvenile/Criminal Justice Treatment Networks Program)
- Educating and providing incentives for community service providers to meet offender treatment needs
- Integrating funding streams and expanding the funding pool
- Coordinating sentencing practices with treatment goals
- Fostering institution and community agency coordination that promotes continuity of treatment (2)

Case Management and Accountability

Case Management

Case management is the coordination of health and social services for a particular client. When provided to offenders, case management also includes coordination of community supervision. Because case managers work across many agencies to serve their clients, they are sometimes known as *boundary spanners*. See TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998b), for more on case management.

Models for coordinating services for transitioning offenders include institution outreach, community reach-in, and third party coordination, in which a separate entity oversees transition. Though any one is appropriate for different circumstances, the Consensus Panel recommends combined models for optimal transition planning. (2)

Ideally, a single, full-time case manager works in conjunction with a transition team of involved staff members from both systems. However, if the infrastructure and resources do not allow for a full-time case manager position, the treatment provider working with the offender or the supervision officer should take the lead in providing this function. (2)

Need for Assessments

To assist in transition planning, the Panel recommends the use of standardized, comprehensive risk and needs assessment tools appropriate to offender populations. These instruments should be "normed" for various populations, including women and racial and ethnic minorities. (1) The instruments should be in the language of the client.

Assessments for offenders should be conducted within the institution as early and often as possible, and also 3 to 6 months before the offender's release. (2)

Multiple assessments of offenders having substance use disorders are necessary and should examine

- Treatment needs
- Treatment readiness
- Treatment planning
- Treatment progress
- Treatment outcome

Risk and needs assessments are ideally conducted by a multidisciplinary team, with cooperation among all players. Areas to be assessed include skills for daily living, stress management skills, general psychosocial skills, emotional readiness for the transition, literacy, and money management abilities. Criminal justice staff can contribute critical information on risk and dangerousness. Assessment results should follow the offender through the system(s). (2)

Accountability

Violations of any aspect of the transition plan must be dealt with consistently, appropriately, and in a timely manner. (1) Innovative sanctions should be developed to address violations. These sanctions are best given in a graduated manner, with the most severe being a return to prison. (1) The methods used should be understood and agreed upon by both the criminal justice and substance use disorder treatment staffs.

There should be periodic reviews of the issues addressed in the transition plan, including legal matters, appropriate placement in a level of care, the effectiveness of sanctions, and the extent to which the offender is meeting expectations. Correctional and treatment personnel should decrease levels of supervision as the offender takes on more responsibility.

An individualized relapse prevention plan should be developed for each offender. It is often developed as a standard form, written in simple, nonclinical language, with a checklist of behavioral indicators that help predict the potential for relapse. The plan should be used by all parties: the offender, treatment agency, supervising officer, and others. (2)

Treatment needs should be reassessed when there are problems (e.g., "dirty" urines, lack of progress in treatment) and, if clinically appropriate, the offender should be moved to a higher or more intensive level of care. (1) The length of stay in the program should be determined by the treatment provider who, along with the community supervision officer, can monitor the progress of the offender.

Guidelines for Institution and Community Programs

Institutions

The term *institution* refers to prisons, jails, and youth detention facilities. Prisons are either Federal or State facilities that usually house offenders for 1 year or more. Prisons represent the end of the adjudication process, whereas jails contain offenders who have not come to trial as well as those with short sentences. Jails are usually run by local governments, though some States, such as Alaska, oversee a jail system. Youth detention facilities provide temporary care and restrictive custody for juvenile offenders (or juveniles alleged to be delinquent). Youth detention can take place pre- or postadjudication, and facilities are usually under local jurisdiction. Regardless of which level of government is responsible for the facility, institution programs should comply with State treatment standards to the extent possible, bringing those programs into a larger context of community-based treatment. To that end, institutional treatment should focus on preparing and motivating the offender for continued care in the community. (1)

The Consensus Panel recommends that jail-based treatment be provided if an offender having a substance use disorder is scheduled for confinement in *jail* for a period of time sufficient to provide adequate treatment for the offender's needs. (1) Nevertheless, even brief jail interventions should introduce treatment concepts to the offender and at least begin the process of fostering treatment in the community. (1)

Treatment providers in prisons should take advantage of the longer period of incarceration to engage in thorough treatment, including frequent reassessments, training in life skills, and discharge planning. Providers should try to offset "institutionalization" by preparing the client for life in the community. (2)

Drug-involved *youth in detention facilities* should receive particularly thorough assessments, and family involvement in treatment should be a strong consideration in transition services. (2)

Community Programs

Community programs should build on the achievements and progress made in prison or jail, rather than starting over with the client. For example, an individual who completes 12 months of in-prison therapeutic community (TC) treatment should enter a community TC program at the commensurate level, rather than entering as if he had never received treatment. (2)

The Consensus Panel makes the following recommendations regarding the goals for communication between the releasing agency and the community supervision and treatment agencies:

- The community program and the releasing agency should discuss the roles of each agency during the transition.
- Community programs should become familiar with the forms and legal requirements used by releasing agencies as well as the restrictions placed on the offender returning to the community (i.e., parole, probation).
- Whenever possible, community programs and releasing agencies should collaborate in designing forms to record offender progress.
- The community provider must find out what kind of therapeutic interventions occurred in the institution and develop a plan for the community program to build on these interventions. Specifically, the community agency needs to determine whether there was
    - A comprehensive substance use disorder assessment
    - A formal substance use disorder treatment program
    - An educational program
    - Vocational training
- Community treatment providers working with offenders should receive education about the prison environment and structure, offenders with substance use disorders, and the criminal justice system in general. (2)

Administrative Guidelines

The administrative meetings to establish a transition team should include a representative of each agency who has authority to speak for the agency, make commitments on behalf of the agency, and sign agreements or other official documents. Each agency involved in setting up the team should have a working knowledge of every other participating agency's policies, internal dynamics, service capacities, and legal responsibilities and authority in relation to the client. (2)

During the planning phase of a transitional services program, it is important to agree on goals that are acceptable to each participating agency. The results of negotiating the key components of a transitional services program should be documented in writing (e.g., an interagency agreement). Interagency agreements should be renegotiated at least every 2 years. (2)

Policy and Procedures

During the planning phase of a transitional service program, it is important for each participating agency to agree on a set of goals. The underlying philosophies of different systems must be identified and discussed prior to program implementation. Failure to do so may foster interagency mistrust, inmate manipulation, and dishonesty and can result in program failure. Partnership goals and objectives must also be compatible with any legal conditions placed on an offender by the releasing or supervisory authority. Other key components that should be negotiated and agreed on between agencies are a shared "vision statement"; each agency's specific roles, expectations, and responsibilities; the timing of tasks; monitoring procedures; information-sharing requirements; client confidentiality; program evaluation needs; who pays for treatment; and methods for resolving disputes. The results of such negotiations should be documented in an interagency agreement. (2)

At the heart of effective transitional services is case management planning. Each participating agency administrator must ensure that the agreements reached among the partners address the timing, methods, and responsibility for case management.

Legislative Issues

Transitional service program administrators should be aware of how State legislatures can affect their programs or larger policies. In response to the ever changing legislative climate, a transitional services program administrator must educate the legislature on the necessity for these services, stay aware of opportunities to help develop new legislation, and identify the need for changes in existing legislation which present obstacles to successful offender transition. The three most important legislative opportunities to enhance transitional services programs for offenders result from provisions made in (1) community corrections acts, (2) structured sentencing laws, and (3) truth in sentencing laws.

State legislatures determine which agency is in charge of parole, probation, and community treatment. The legislature may also determine the agency in charge of transition to the community and/or community-based substance use disorder treatment. A transitional services program administrator must be aware of the States' legislative position on these issues and the current structure of these services to effectively navigate the planning and implementation processes. If there are obstacles, the administrator must be able to identify and work with those obstacles. The kinds of legislative obstacles a transitional services program administrator might expect to encounter are (1) determinant sentencing laws, (2) presumptive and mandatory minimum sentencing laws, and (3) legislative treatment mandates.

Confidentiality

Client confidentiality and the offender's right to privacy must be balanced against the needs of various agencies for information. The extent of computerization and the security of client data across agencies are areas of crucial concern in partnerships between various transitional services. During the planning process for information sharing, these issues should be addressed in great depth.

It is essential for the administrator charged with managing a transitional services program both to understand confidentiality regulations and to work out methods by which clients are informed of their rights. All staff members involved with transitional services need training on the parameters of client confidentiality. (2)

Program Evaluation

Because multiple agencies are involved in transitional services programs, certain evaluation issues must be addressed at the planning process phase. These include what data will be used; who will be responsible for collecting data; who will assist in data interpretation; and what, how, and to whom data will be reported. Participation of the evaluator and the cooperation of partners involved in the evaluation must be obtained early in the process because successful program evaluation depends on their full cooperation.

The many uses of information gathered from a program evaluation include

- Justifying program costs and identifying cost offsets
- Establishing program effectiveness or success
- Making program adjustments
- Assisting in legislative decisionmaking and funding allocation
- Serving as a basis for obtaining additional funding
- Serving as a justification for expanding services (2)

Process evaluation examines the implementation procedures and operations of a transitional services program as it compares with the program's stated goals and objectives. Outcome evaluation to determine effectiveness of a program can be conducted by comparing the group receiving services to a control group that receives no treatment, an alternative program, or standard treatment.

The focus of outcomes measurement should be on behavioral changes, such as reduced drug use or abstinence, stopped or reduced criminal activity, compliance with supervision requirements, and stability within the community.

Ancillary Services

Offenders with substance use disorders need certain basic services as they reenter the community, including housing, employment, health care, and possibly family counseling. These services are generally provided by a number of public systems that are not well-coordinated and, because of the factors discussed throughout this TIP, offenders' abilities to access these services are limited. However, efforts at treatment are unlikely to succeed unless these basic needs are met.

Housing

Because safe, secure, and substance-free housing is so important—and often difficult to obtain—a housing plan should be in place before release from incarceration. (2) Offenders, along with the transition team responsible for this service, should identify a living arrangement that meets their needs and then arrange a linkage with the entity providing housing. Local housing agencies can be brought into the team as partners in this effort.

Employment

Planning for employment should begin well before release. Close collaboration with the welfare/workfare system is essential to avoid employment conflicts between the criminal justice and local social service agencies, which both have authority over the offender's fate. While still incarcerated, offenders can benefit from prevocational and job training, job readiness preparation, skills identification and assessment, role playing for future interviews and job situations, and reach-in programs that serve as quasi-internships or offer transferable pre-employment experience. Prior to release, case managers often develop a resource directory of employers that will hire offenders and talk with probation and parole officers about employment possibilities. The offender should be linked with employment services before release from the institution. (2)

Family

To the extent the offender's family agrees to participate, a prerelease assessment of the family environment should be conducted. This assessment should measure

- Whether other family members are using substances
- Whether there is domestic violence
- Criminal activity of other people living in the house
- The level of support for sobriety
- Hopes regarding family reunification
- Current child care and child custody status

- The availability of family members in nurturing roles
- The family services already in place
- Areas of potential vulnerability (2)

Peers

Permanent sobriety often involves avoidance of people, places, and things that may trigger relapse. The case manager (or those providing case management functions) can guide an offender toward new contacts. Formal peer support groups are invaluable. (1) A directory of peer groups and services can be maintained by the case manager, who should also identify whether support groups are open or closed, their focus, and where they are located.

Recommendations for Coordinating Ancillary Community Services

- Service providers in a community coalition should convene to promote access to offenders as they make the transition into the community. This builds linkages among different service systems and facilitates the job of the case manager or boundary spanner.
- Representatives of all involved service agencies and programs should meet face to face to explain what services they have to offer and exchange phone numbers and specific information about their programs (such as the name of the contact person and how many slots are in the program).
- Service providers should create networks to link with the legal sanction agency.
- The corrections system should make contracts with community organizations providing formal services, such as residential and outpatient substance use disorder treatment services, job training, and life skills training.
- If possible, and in partnership with other agencies, treatment providers should endeavor to ensure substance-free housing for offenders re-entering the community. In addition to providing the obvious need for shelter, supported housing arrangements provide a positive social setting because the other tenants, also in transition, can give support to one another.
- Providers should modify conditions of community supervision to promote participation in services (e.g., parenting classes, substance use disorder treatment).
- Treatment managers should train corrections and supervision staff about substance use disorder issues. (2)

Special Populations

Though treatment providers know that people with substance use disorders are extremely diverse, offenders tend to be treated as a homogeneous population. The effects of incarceration are different depending on a client's gender, culture, background, or age, and their treatment needs vary accordingly.

Furthermore, a higher proportion of offenders than of the population at large have mental illness, mental retardation, physical disorders, or long-term medical conditions. (1) Effective care for those with health problems must incorporate the care of these illnesses into the plan for treatment of substance use disorders and criminality. To provide effective care for diverse populations, assessment and treatment efforts must also acknowledge and incorporate cultural differences.

Ideally, staffing patterns at all levels of the treatment system will reflect the population served, from clerical staff through executive management. Specific efforts should be made to recruit and maintain these staff members. Licensing, certification, and credentialing should support the use of culturally competent staff—and support continuing education in the knowledge and skills relevant to the population. Staff members should be able to communicate in local languages and dialects, and published materials and consent forms should be available in these languages as well. In-service training and ongoing staff development should include issues related to specific populations.

Women

Women offenders' unique issues include child care, health issues, lack of employment experience, and possible victimization by their domestic partners. (1) Case management is particularly important when the offender is a mother. Parenting classes and quality child care may be essential for some women to make a successful transition.

Counseling and testing for all sexually transmitted diseases should be available to female inmates and be part of the transition plan. Because many incarcerated women have little or no work experience, elementary and intensive job readiness training and job seeking assistance should be available.

Many female offenders have been victims of physical or sexual abuse, and many may be returning to abusive situations upon release. Case managers should explore this issue as a critical part of the transition plan, and alert community treatment providers. If an offender has no safe place to go, she should be directed to a women's shelter.

The Consensus Panel recommends women-only programming wherever possible. (1)

Elderly Offenders

Older prisoners have more health problems and long-term medical conditions than their younger counterparts. The stress of return to the community can be much greater for elderly offenders, especially if they have been incarcerated for many years and have no family or familiar sources of support.

There are a variety of services and entitlement programs that older offenders returning to the community may need help accessing—Medicare, Social Security, or perhaps veterans' benefits. Their transition plans are more likely to require a search for supported living arrangements, such as nursing homes. It is especially important to have someone who can oversee medication management on the transition team. (1)

Offenders With Mental Illness

Incarcerated substance-users have high rates of coexisting mental health disorders; it is crucial for these offenders that medication orders and files are transferred. Careful reassessment of the inmate's medication is required upon release to the community.

Case managers should foster intersystem communication, as the mental health and substance use disorder systems are sometimes separate in prison and usually separate in the community as well. They also must work to identify funding to cover care for offenders with coexisting disorders. In the current environment of managed care, advocacy for this population is essential.

Sex Offenders

Generally, it is useful to address the sex offender's behavior prior to focusing on substance use disorder treatment issues. Because many States are now eliminating programs for sex offenders, the substance use disorder treatment community may become the first line of treatment for many of these individuals; this highlights the field's need for an indepth understanding of this population.

Long-Term Medical Conditions

Tuberculosis, hepatitis, and HIV/AIDS are more common in prisons and jails than in the community, so offenders are more likely to suffer from one or more of these problems. If offenders have had their medical needs met in prison, it will help facilitate a smooth transition back to the community. It is critical that there are no gaps in treatment or the receipt of medications.

The Panel recommends the mainstreaming of those with HIV into treatment groups. (1) HIV and other support groups within the community can enhance the effectiveness of substance use disorder treatment.

Offenders With Disabilities

A balance must be struck between providing special services for people who are disabled and mainstreaming. Sometimes special treatment programs will be necessary. In other instances, minor modifications can allow these individuals to participate in programs with the general population.

A screening for disabilities, including traumatic brain injury or certain physical conditions, should be conducted at intake into the correctional system. When the offender returns to the community, all relevant medical information should be transmitted to the appropriate parties. If medication is used to treat the disability, it is important that there is no gap in its use.

Many advocacy groups safeguard and promote the interests of persons with disabilities, who are protected by the Americans With Disabilities Act. During the transition period, contact should be made with representatives of these groups. For more information on this topic, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT, 1998c).

Maintaining Sobriety

Release from incarceration is an extremely high-risk event for someone in recovery for a substance use disorder. It is critical that treatment gains be maintained as the offender moves into a new life with added responsibilities and stresses. Because offenders' relapse to substance use is so often accompanied by a return to criminality, maintaining sobriety is a public safety issue as well. Ideally, the institutional treatment program and the community provider share responsibility for the transition.

To help smooth the transition process, this TIP recommends ways in which those who work in the criminal justice system and community treatment providers who have little exposure to the incarceration system can collaborate and complement one another's efforts. The Consensus Panel that generated this TIP includes experts from across the substance use disorder treatment and criminal justice systems. Dozens of additional experts reviewed the document. The professionals who contributed to this book do not agree on every issue, but the TIP reflects those areas where consensus was reached. To avoid sexism and awkward sentence construction, the TIP alternates between "he" and "she" in generic examples.

1 Introduction

On any given day, some 1.7 million men and women are incarcerated in Federal and State prisons and local jails in the United States, and a recent study suggests that more than 80 percent of them are involved in substance use. In 1996 alone, taxpayers spent over $30 billion to incarcerate these individuals—who are the parents of 2.4 million children. Put another way, one of every 144 American adults is behind bars for a crime in which substances are involved (The National Center on Addiction and Substance Abuse at Columbia University [CASA], 1998).

By a variety of measures, it is clear that substance use disorders disproportionately affect incarcerated Americans (Reuter, 1992; CASA, 1998; Federal Bureau of Prisons, 1997). Yet this population is significantly undertreated: Although prison substance use disorder programs annually treat more than 51,000 inmates, this figure represents less than 13 percent of the offender population identified as needing treatment. Studies also indicate that (with the exception of detoxification) most offenders have never received treatment in the community (Lipton et al., 1989; Peyton, 1994). Clearly, the majority of individuals in the criminal justice system in need of substance use disorder treatment are not receiving services—either while they are incarcerated or after release to the community.

Providing substance use disorder treatment to offenders is good public policy. Recent research shows that punishment is unlikely to change criminal behavior, but substance use disorder treatment that also addresses criminal behavior can reduce recidivism (Andrews, 1994). Inmates with substance use disorders are the most likely to be re-incarcerated—again and again—and the length of their sentences continually increases. The more prior convictions an individual has, the more likely he has a substance use disorder. In State prisons, 41 percent of first offenders have used drugs, compared to 63 percent of inmates with two prior convictions and 81 percent of inmates with five or more prior convictions. Half of State parole and probation violators were under the influence of drugs, alcohol, or both when they committed their new offense. State prison inmates with five or more prior convictions are three times more likely than first-time offenders to be regular crack cocaine users (CASA, 1998). Offenders with substance use disorders not only crowd the nation's prisons, they are also responsible for a disproportionate amount of crime and for relatively violent crime. Compared to offenders who do not use drugs, drug-using "violent predators" commit many more robberies, burglaries, and other thefts (Chaiken, 1986).

However, offenders who have completed substance use disorder treatment during incarceration are still at great risk for relapse and recidivism when released. They need a variety of services to maintain sobriety during their transition from the institution to the community. This chapter provides an overview of the benefits of those transitional services. It also discusses obstacles to implementing such services and provides strategies for overcoming these obstacles. Finally, models for transitional services are described.

Benefits of Offender Treatment

Treatment During Incarceration

Some incarcerated offenders enter treatment for the same reasons as those "on the outside": They want to stop using substances and need help. Others, however, may have different motivations: boredom, the desire to improve their chances for parole, a wish to escape the violent culture of general population, or some combination of the above. Others may be mandated to treatment by the courts. Surprisingly, research shows that once an offender begins treatment, outcomes are not affected by the reasons for entering treatment (Leukefeld and Tims, 1988). A certain proportion of those who undergo treatment within the institution will succeed if supervised closely (Anglin and McGlothlin, 1984; Petersilia et al., 1992). Other key findings on the effectiveness of substance use disorder treatment within correctional institutions include the following:

- Prerelease therapeutic communities have shown high rates of success among inmates studied (Wexler et al., 1988; Field, 1989).
- Involvement in substance use disorder treatment is associated with decreased criminal recidivism. Improvements have been seen in rates of rearrest, conviction, reincarceration, and time to recidivate (Field, 1995a; Inciardi, 1996; Peters et al., 1993; Swartz et al., 1996; Wexler et al., 1990).
- Involvement in substance use disorder treatment is associated with decreased substance use and relapse and other health-related outcomes (Inciardi, 1996; Martin et al., 1995; Wexler et al., 1990).
- Duration of correctional substance use disorder treatment is associated with positive treatment outcomes. Research has shown that, up to a point, longer lengths of treatment are more effective than shorter lengths of treatment for substance-using offenders (Swartz et al., 1996; Wexler et al., 1992).
- Involvement in substance use disorder treatment, such as prison-based therapeutic communities, is associated with successful parole outcomes (including reductions in parole revocations) (Field, 1989; Wexler et al., 1992).
- Inmates involved in substance use disorder treatment had reduced rates of re-arrest and relapse when compared with inmates who did not participate (Federal Bureau of Prisons, 1998).

Treatment During Transition To the Community

Service systems should provide offenders with appropriate treatment, since no treatment is likely to lead to continued drug use and crime. Treatment that stops when the offender is released, however, may not be enough. Release presents offenders with a difficult transition from the structured environment of the prison or jail: Despite the hardships endured "inside," they at least knew what to expect. Many offenders are released with no place to live, no job, and without family or social supports. They often lack the knowledge and skills to access available resources for adjustment to life on the outside, all factors that significantly increase the risk of relapse and recidivism (Leshner, 1997). The positive effects of substance use disorder treatment within correctional institutions may diminish once the offender moves out of the institutional environment unless followup care is provided in the community (Martin et al., 1995; Peters et al., 1992; Swartz et al., 1996).

The benefits of treatment during the transition from incarceration to the community are substantiated in several recent studies. In a study of drug offenders in Delaware, offenders who participated in 12 to 15 months of treatment in prison and another 6 months of treatment in the community were more than twice as likely to be drug-free 18 months after release as those who had only the prison treatment. Those offenders were also arrested much less in the year and a half following release (Inciardi, 1996). A similar study in California had comparable results (Wexler, 1996). Continuity of care from the institution to the community is associated with positive outcomes for prevention of relapse and criminal recidivism in other research as well (Swartz et al., 1996; Wexler et al., 1990).

A demonstration program in the Oregon Department of Corrections reduced re-arrest rates and conviction rates among inmates participating in a transition program (Field and Karecki, 1992). This program emphasized transition from the institution and treatment in the community, rather than providing intensive treatment within prisons and jails, along with a postrelease aftercare program.

Why Continuity of Treatment?

Because substance use disorders are long-term, recurring illnesses, continuity of treatment is important for everyone. Studies show that the most effective treatment lasts at least 3 months, and outcomes improve with additional time in treatment. This is true for all treatment modalities and particularly for treatment of offenders (Hubbard et al., 1989; Simpson, 1984; Wexler et al., 1988). Continuity is especially important for someone leaving a correctional institution. The offender may be so acclimated to a highly structured correctional environment that everyday decisionmaking in the community is overwhelming. Many addicted offenders, like individuals with other disorders, have particular trouble transferring learning from one setting to another, so that many of the gains made in treatment are lost unless there is continuity of care.

Figure 1-1

Criminal Justice System Definitions

Many references to community supervision are made throughout this TIP. The following list of general definitions may help a reader who is not familiar with the criminal justice system. However, the definitions may vary slightly from place to place because jurisdictions organize their supervision systems in different ways.

Probation is typically court-ordered supervision imposed in lieu of jail or prison.

Parole is supervision imposed at the end of a jail or prison sentence, perhaps shortening the period of incarceration. As with probation, parole may be revoked, resulting in the individual being incarcerated.

Postprison supervision is used to describe supervision following a completed period of incarceration. Some States have replaced their parole systems with postprison supervision.

Community supervision is the general category that includes all the terms listed above. There are other forms of community supervision as well, such as courts that have their own supervision systems. In this TIP, community supervision is the most commonly used term. A community supervision agent, then, could be a parole officer.

In short, the offender is vulnerable to relapse into a substance use disorder and crime during the early release period. Without coordination between institutional treatment and community-based treatment, offenders are likely to relapse and return to criminality. At the most basic level, continuity of treatment consists of communication and information sharing between institutional treatment and release services personnel, community supervision staff (parole or postprison supervision), and community treatment staff. This information sharing and planning needs to take into account all the ancillary services the individual needs.

Continuity makes sense not just for offenders being released from jails and prisons, but in the context of the entire criminal justice system. The fragmentation of the various functions—arrest, diversion, conviction, probation, revocation, jail, prison, and postprison supervision—undermines the effects of treatment and of other aspects of offenders' rehabilitation. Offenders, particularly repeat offenders, often have antisocial personality disorders and may exploit any gap in supervision or monitoring. Any break between treatment in prison and treatment in the community is an invitation to relapse for such offenders. Ineffective continuity diminishes treatment gains, wastes treatment resources, and endangers the community.

Obstacles to Effective Postrelease Transitions

Treatment continuity from the institution to the community can mean the difference between a career criminal and a productive member of society. Despite its importance, the obstacles to continuity of treatment are substantial. Most barriers stem from the structure of public sector systems, such as fragmentation of the criminal justice system, community providers' lack of attention to offender issues, and funding barriers. To overcome these obstacles, corrections and treatment systems need to clearly identify and understand them. Key obstacles are listed below; recommendations for overcoming them begin on page 8.

Lack of System Coordination

The criminal justice system is not a discrete, well-coordinated system, but rather a cluster of independent agencies and entities with separate justice responsibilities. Of those entities—law enforcement agencies, bonding authorities, jails, pretrial release agencies, courts, probation agencies, community-based service providers, prisons, and parole agencies—some may collaborate closely, while others function independently. Most operate under separate funding streams, with differing organizational missions that may or may not share philosophical orientations toward public safety and offender rehabilitation.

An offender's tour through the criminal justice system may include encountering the police when she is arrested, spending time in jail before or during trial, being reviewed for treatment needs by the court before or after sentencing, being diverted from prison to probation, having probation revoked and being sent to prison, and then being placed on parole following a prison sentence. Each step may involve a different agency. The Criminal Justice Treatment Planning Chart (Center for Substance Abuse Treatment [CSAT], 1993) provides a detailed guide to both treatment intervention opportunities and places where an offender could fall between the cracks within the typical criminal justice system.

This fragmentation inhibits transfer of information about the offender and results in duplication of some services, such as assessment, and a gap in the continuity of other services, such as case management and treatment service delivery. In many jurisdictions, institutional programming is run by an executive agency, while probation may be part of the courts. Even when all correctional interventions are part of the same administrative agency, the gaps between institutional and noninstitutional services can be significant. Legal issues, particularly confidentiality, may keep information out of some transition team members' hands.

Unfortunately, the gaps in information lead to a lack of accountability for the offender upon release or transfer. Both the criminal justice and treatment systems need as much information as possible about an individual in order to ensure continuity of care; each should take advantage of the increased technical capabilities for automated information systems.

As the number of substance-using offenders escalates, and the health and social service systems that must be accessed upon release become increasingly complex, interagency linkages between correctional, health, and substance use disorder treatment systems are critical. Staff from all systems should look for opportunities to advocate for clients by brokering among different systems, facilitating immediate treatment based on periodic assessments, and learning methods for system collaboration.

Unclear lines of authority and responsibility

Every member of the transition team must understand the urgency of continuing treatment immediately following release to prevent relapse or recidivism. Prison and jail officials should coordinate release of offenders with openings in treatment programs so the offender has support in the stressful period following release. Something or someone—possibly an offender tracking system or a boundary spanner (discussed below)—is needed to ensure that the link between treatment in the institution and the community actually takes place.

Treatment providers often deal only with substance use disorder issues, but may not play a role in other practical needs, such as facilitating the offender's relationship with the probation or parole officer. If an offender misses a curfew because a group program runs long, and if the treatment provider does not understand the supervision conditions, she may be unwittingly involved in the offender violating parole. Joint staffing, collaborative planning, and policy development as well as staff cross-training can minimize these kinds of problems.

Different expectations

Significant differences in philosophy and approach between treatment settings in the institution and in the community can make transition to community treatment very difficult. The treatment approaches and client expectations of a community-based system may differ dramatically from a residential treatment program in a prison, jail, or other institution. Offender clients who are newly released from incarceration may be seen as noncompliant, when they are actually confused about expectations in the new setting. Offenders may not have much recent practice in personal accountability or decisionmaking because they were so strictly controlled in the institution, and many offenders have trouble generalizing coping skills learned in the institutional setting. They also may take advantage of service providers. While no generalization applies to every person who is incarcerated, a major part of jail and prison culture is "working the system." Community providers should not prejudge offender clients, but they should be alert to the possibility that the client may well manipulate and lie to them.

Lack of Attention to Offender Issues by the Community Service System

The criminal justice population contains many who need substance use disorder treatment, yet within most community programs few specialized staff are assigned to meet offenders' needs. This is in part due to the fact that State and local substance use disorder treatment agencies have not always identified offenders as a priority population, and those agencies that provide community supervision do not always fund treatment services during probation or parole. Though offenders remain an underserved population, national, State, and local efforts have improved community treatment responsiveness to offender populations during recent years.

Another problem area may be that program licensing and State credentialing standards do not take into account the needs of the offender population. Although recently, a criminal justice treatment professional certification process was developed by the Certification Board for Addiction Professionals of Florida and the International Certification and Reciprocity Consortium. Counselors sometimes provide treatment services without appropriate supervision or monitoring. One obstacle to effective treatment may be the policy of some programs to restrict the hiring of exoffenders as treatment counselors. Such staff members can improve a program, because they may relate more readily to the needs of these clients than those whose background differs substantially from the population served.

Funding Complications

As with most systems relying on funding from the public sector, both criminal justice and substance use disorder systems experience financial difficulties due to disconnected funding streams and competition for limited funds. Offenders making the transition from the correctional system to substance use disorder treatment in the community face an additional obstacle, in that they need services from both systems yet may not fit readily into either funding category. Available dollars are earmarked for either institutional or community services, but not for coordination between the two. Funding streams typically flow to specific divisions of social service agencies and are available only for a narrowly defined population. Prison services are usually State-funded, while community services are often county-funded. Some funding sources, including Medicaid, cease when the recipient enters prison. Ironically, funding available from some Federal agencies is not used because the population defined as needing it cannot get access in the current system.

Managed care organizations are increasingly involved in treatment decisions and may not agree with the community treatment plans for the offender. Managed care representatives may regard institution treatment as sufficient or assume that an offender who has been abstinent throughout incarceration does not need treatment. Managed care decisionmakers also may simply opt for a lower level of care than is deemed necessary by corrections or local treatment staff. New York requires managed care organizations (MCOs) to cover court-ordered offenders who may not meet the "medical necessity" criteria of the MCO. New York is currently the only State with such a law, even though many in the justice system consider public safety a more relevant treatment criterion than medical necessity.

The lack of funding for institutional programs is particularly problematic in small, rural jails and in some State prison systems. For example, a nationwide survey found that only 9 percent of small jails (fewer than 50 beds) had a funded substance use disorder treatment program, as compared to 60 percent of jails with more than 2,000 beds (Peters et al., 1992). Nor is there enough funding to create the capacity for needed community and institutional services, or for special populations such as women, women with children, and offenders with mental illness. Services are sometimes discontinued as offenders are released from jail or prison because there is no case manager to advocate for the offender. Offenders are put on waiting lists or do not receive appropriate treatment. This in turn leads to poor retention in treatment and negative outcomes (e.g., relapse or recidivism).

Typically, the only treatment services that are reimbursable in the community involve direct contact with the client, such as individual counseling, group therapy, and assessments. This is true whether the funding entity is a single State agency, a managed care plan, or Medicaid. However, what will be paid for is not necessarily what clients need. Those services for which community treatment programs are reimbursed, and areas that are the focus of performance evaluations, are not necessarily the services needed by offenders making a transition from institutional settings. For example, a significant amount of time must be spent interacting with various agencies to create linkages on behalf of the offender, yet such case management services often are not reimbursable.

Funds are rarely targeted specifically for transitional services, although innovative programs are being conducted now in Texas, Delaware, Oregon, California, and New York. The Federal prison system included a transition component in its 1989 program design, and Congress has funded this national transitional effort. Clear articulation of the public safety benefits of specific transition services helped the Federal system obtain this funding. Some jurisdictions are beginning to capitalize on the investment made in institutional treatment by supporting specific community-based services to promote continued or ongoing recovery.

For example, since August 1996, the New York State Division of Parole has channeled funding to the State Office of Alcoholism and Substance Abuse for contracts with local treatment agencies which agree to admit offenders on a priority basis. Under the agreement, the agencies also provide enhanced case management services to people released from the Willard Drug Treatment Campus (DTC). Willard DTC is a State-run, 850-bed, licensed treatment facility for substance-using, nonviolent felons. Payments to providers are performance-based.

Coordination of Sentencing and Treatment

Whenever possible, treatment should be structured to fit within the sentence imposed by the court and, conversely, sentences should be structured to accommodate the treatment needs of the offender. The latter requirement can take several forms: Sentences can be structured so that assessments are ordered, and the defendant must follow the recommendations for treatment. In some jurisdictions, the court will modify a sentence to accommodate treatment participation after the initial imposition.

The legal system is structured to determine guilt or innocence and the primary emphasis of the court is on public safety—typical presentence and probation reports focus on risk to the community and the legal issues surrounding the defendant. Although courts have no legal obligation to attend to the substance use disorder treatment needs of offenders, some have recently taken a proactive role, recognizing that addressing substance use disorders can reduce further criminal activity and enhance public safety. The proliferation of treatment drug courts, offender-dedicated treatment programming, and alternative sentencing that includes treatment are examples of this trend.

For such programs to work, judges must be given the information they need to mandate treatment participation, particularly the need for and availability of treatment. Prior to any treatment mandate, the court should receive the results of a thorough substance use disorder assessment of the offender, performed by a qualified professional. Mandating treatment without such a qualified assessment may be seen (understandably) as retribution or punishment. Judges will also need clinical guidance in order to shape the appropriate and specific treatment interventions. Inappropriate placement in a jail or prison program, therapeutic community, or community treatment program can contribute to dropout, lack of service provision, or wasted resources. Judges also need to follow through with swift and certain sanctions for offender noncompliance.

With the advent of new criminal justice initiatives such as the Treatment Alternatives to Incarceration Program in Texas, judges can obtain more information to make treatment recommendations in their sentences.

Judges can play a critical role in the treatment of offenders by crafting sentences that enable or require treatment participation, by responding when there is a crisis or change in circumstances that requires additional treatment or supervision interventions, and by making appropriate accommodations when the offender meets treatment goals. Such judicial oversight is featured in various treatment drug courts and programs, such as CSAT's Juvenile/Criminal Justice Treatment Networks, Birmingham's Breaking-the-Cycle, and Treatment Alternatives for Safe Communities (TASC). In treatment drug court programs, supervision, treatment, and case management services are linked to the court, with individual oversight of each offender provided by a judge. Depending on the jurisdiction, offenders participate in these programs in lieu of or as part of a criminal sentence. In treatment drug courts, judges hold special "status hearings" to monitor the progress of offenders in treatment throughout their stay in the program.

In New York, the Brooklyn District Attorney's office took a leadership role in 1990 by beginning a program called Drug Treatment Alternative to Prison for defendants facing mandatory prison sentences, thus giving the prosecutors and judiciary a mechanism to sentence prison-bound nonviolent drug offenders to residential treatment, usually a therapeutic community. The program has been experiencing about a 70 percent retention rate in treatment since its inception. Six counties in New York State are now using this model. TASC is also used in some of these counties to assess, refer, and case manage.

Offenders are significantly more likely to continue in treatment after release if they are placed under community supervision (Hubbard et al., 1989) with conditions specifying involvement in treatment. While transition planning benefits all offenders, it is particularly important to offenders who need substance use disorder treatment.

Recommendations for Overcoming Obstacles

Integrating systems

- View the offender's problems as the responsibility of both systems, and the offender's success as benefiting both systems.
- Make planning systems-wide, in local jurisdictions as well as at the State level.
- Establish and maintain a cross-system criminal justice/substance use disorder treatment planning body.
- Initiate joint case staffing.
- Establish protocols for sharing all information relevant to the offender's case while meeting confidentiality and privacy requirements.
- Cross-train staff.
- Create contract provisions that provide incentives for agencies to work together toward good outcomes (performance-based contracting).
- Coordinate systems that have supporting functions, such as welfare and family services departments.

- Community treatment providers should establish contact with substance-using offenders before they are released to establish trust and rapport.
- Prepare individual contracts specifying treatment appointments, frequency of meetings with the parole officer, frequency of urine tests, and vocational expectations, so that all requirements and goals are stated in one written agreement.
- Establish criminal justice monitoring in the community through the use of split sentences, work furlough programs, probation, or other options that create a transitional setting before full re-entry into the community.
- Provide offenders with incentives to engage in voluntary treatment.
- In the absence of traditional parole, the jurisdiction and the State should develop alternative strategies for providing structure, accountability, and monitoring such as postprison supervision.
- Designate a case manager, mentor, or boundary spanner to oversee the transition from the institution to the community. This person could perform a range of duties, from acting as a liaison between systems to picking up the offender upon release and taking her to a treatment program.

Increasing awareness of offenders' needs

- Develop specialized services and programs serving the multiple needs of offenders.
- Publicize the need for services at the State level and encourage their inclusion in treatment, criminal justice, and health and social services planning documents at both State and local levels.
- Offer outcome research demonstrating the positive effects of transitional services to funders.
- Recruit and develop staff with special expertise treating offenders.
- Examine State licensing and certification processes/standards to ensure appropriate staffing and programming models specific to offenders.
- Work toward more comprehensive system integration, including
  - Co-location of treatment and community supervision services
  - Joint planning
  - Joint case management

Obtaining and simplifying funding

- Correctional institutions should fund, at a minimum, substance use disorder screening, assessment, and prerelease planning, unless offenders are moved to transitional institutions on the basis of treatment needs.
- The following agencies should consider sharing resources to provide transition services:
  - Corrections and treatment
  - Probation, parole, and treatment
  - Child protective services and treatment
  - Social services and treatment
  - Treatment providers from different programs
  - Managed care plans
- These entities should look for nontraditional sources of funding, such as
  - Department of Housing and Urban Development
  - Department of Veterans' Affairs
  - Foundations
  - Department of Labor
  - Local monies
- Establish the activities of boundary spanners or case managers as a billable service.
- Write performance-based contracts that base reimbursement on realistic outcomes, such as engagement in transition services and successful reintegration in the community. Other measures can include reduction of drug use and criminal activity, financial

stability, finding suitable housing, or reaching a higher educational level.

Coordinating sentence and treatment

- Both the institution and the community should attempt to accommodate the treatment needs of offenders, regardless of sentence length.
- Develop a variety of institutional treatment tracks for offenders with varying lengths of stay.
- Keep treatment plans flexible enough to respond to offenders' needs; devise a system for modifying a sentence based on treatment progress and other compliance measures.
- Structure sentences so that services, supervision, sanctions, and rewards encourage compliance.
- Encourage development of more court-based services, such as presentence investigation services through local probation offices, to help identify offenders who would benefit from treatment services (both inside and outside the institution), and to determine the duration of treatment needed and the type of treatment setting needed.
- Educate judges, probation officers, and community supervision staff (in part with pretreatment reports) about the use of split sentences that require both institutional and community treatment.

Program Strategies

Three basic types of program models are used to provide transitional services for offenders being released: *outreach*, *reach-in*, and *third party*. In an outreach model, the correctional institution designates staff to make linkages to appropriate services in the community, while a reach-in model places the initiation of transitional services with the community programs. These models are not rigidly structured, nor are they mutually exclusive. They have many elements in common (see Figure 1-2). The ideal program uses components of each, so that the institution can identify services in the community at the same time the providers in the community initiate treatment and transition services prior to release. A variation on these two options that works well in some jurisdictions is contracting with a third-party entity to coordinate some or all transitional services.

Institution Outreach

In this model, a member of the institution's staff initiates linkages with agencies and services beyond the institution. Among the services that require coordination are community substance use disorder treatment and other social services, parole or postprison supervision, and work release programs.

Figure 1-2

Characteristics of Both Outreach and Reach-in Models

- Early prerelease planning
- Development of an effective community reentry and relapse prevention plan
- Establishment of linkages among service systems as designated by the plan
- Incorporation of continued community treatment plans as a condition of parole or probation where possible
- Monitoring the offender to ensure that linkages have been made, that transition services are appropriate, and that new issues that have arisen are being addressed
- Establishment of a standard protocol for this function within the system's infrastructure
- Contracted third-party services can fit with either model

Key components

The primary responsibility for success of the transition lies with the case manager (or those who are collectively providing case management services). In an ideal situation, this function is assigned to a designated staff person. That person is responsible for services as the client moves from incarceration to the community.

The institution can support and foster outreach activities and prioritize followup of offender services. Institution services can also provide resources to ensure that the offender is engaged in treatment and that the services being received are appropriate.

The case manager should not be confined to making phone calls and sending letters from the institution, but should have face-to-face contact with the representatives of service agencies. Although clinical training is quite useful, other important skills for case managers include

- Ability to leave the institution to develop community transition networks
- Familiarity with community resources and the systems within which they operate
- Understanding of eligibility criteria for the services needed
- Ability to get the offender into the services

Equally important as these skills is a case manager's commitment to the continued recovery and improvement of the offender. The case manager may wish to develop a community resource directory to describe the range of services available and which agency can be used to link the offender to other services. He should also conduct orientations for community-based agencies in which he meets with staff providing aftercare services and describes the needs of the offender. The case manager describes the nature and approaches used in the institution treatment program. Open discussions about offender needs and the services offenders have used help gain the local treatment agencies' trust and help them become more willing to accept corrections clients.

In an ideal transition, the offender is an active participant in the entire process. Offender participation helps teach the offender responsibility and secures her "buy-in" to the services that will be critical to her adjustment and continued success in the community. In situations in which there are no resources for a dedicated case manager, a mentor or other volunteer can be assigned to assist the offender and serve as a broker in finding services. This approach has been used successfully in some localities. The relationship could begin while the offender is still incarcerated and would continue upon release, at which time the volunteer would meet with the offender and take him directly to a treatment program or meeting. The volunteer could then provide coordination functions on behalf of the offender with correctional and community staff. An institution parole officer (available in some States), with training and agency support, may also fulfill the case management function.

When is this model most effective?

Based on clinical experience, the Consensus Panel recommends the outreach model when case management resources are available in the institution, including necessary funding and a designated staff person to do transition planning. This model should be considered when there is an infrastructure of well-coordinated treatment services within the institution. If community treatment providers are not able to perform transitional services, the institution should take the initiative. The outreach model works best when the institution, community services, and the residence of the offender (upon release) are all in close proximity.

Community Reach-In

Under this model, community programs assume primary responsibility for initiating treatment and transitional services before the offender's release. Staff members from the community agency "reach in" to the institution and begin the process of preparing the offender for transition and establishing necessary linkages.

Key components

As with the outreach model, the case management function is critical; however, in this case the person designated for this role is from the community agency rather than the institution. This person may be from a community treatment agency or may be employed by the community supervision agency. Service providers may come into the institution and conduct prerelease groups to describe the goals of treatment and the services they have to offer, both for the benefit of the correctional staff and the offender. They may also provide an orientation for offenders that helps with prerelease planning and educates the offender about what to expect. Reach-in transition should include at least one face-to-face interview involving the offender and both institution and community-based staff to determine the offender's plans after release. This interview should yield an assessment of the extent of progress made during institution treatment and the specific need for community treatment after release. These interviews should be conducted at the same time that the risk and needs assessments (discussed in Chapter 2) are completed. Given the potential conflict of interest of referring solely to one's own community agency, provider recommendations for an offender's continued treatment should be based on each client's individual treatment needs. Treatment providers should agree to utilize the full spectrum of local treatment services.

The community provider needs access to information about institution treatment participation and related activities so the foundation laid in the institution can be built upon (and not duplicated) after release. The transfer of assessment information and any treatment/release plans should occur during the prerelease planning stage. The offender's consent is needed to transfer information about treatment participation. After release, a feedback loop can communicate whether the offender made the link to treatment and describe the services being provided and the attendance and progress of the offender.

The Federal confidentiality regulations (42 Code of Federal Regulations [C.F.R.] Part 2) complicate this feedback loop, except in those instances where the feedback is to the criminal justice agency that mandated the offender's participation in treatment. In other situations, the offender must consent to the community provider sending the institution feedback. The ordinary 42 C.F.R. consent form must then be

Reach-in Model Program: Single Parent Resource Center's Healthy Horizons Program

This New York State program helps female offenders in a number of prisons make the transition into the community. The program sends a staff person into the prison to conduct a workshop about issues involved in the transition process, including substance use disorder issues, housing, income, and parenting. Once the women are released, the program provides them with substance use disorder relapse prevention services, supportive group counseling, and case management services. It also helps the women reunite with their children by hosting weekly meetings where parent and child can become reacquainted after a long separation in a pleasant, nonpressured atmosphere and by arranging visits at its offices between mothers and children (for those who lost custody).

used, which means the offender can revoke the consent form (although he is unlikely to do so).

When is this model most effective?

Based on clinical experience, the Consensus Panel has found the reach-in model most appropriate when community providers are able and motivated to serve offender clients. Reach-in case management is most necessary when the institution lacks transition staff or resources. This model is especially appropriate for jails, because the shorter term makes rapid engagement more critical. The treatment providers have the opportunity to conduct assessments and make recommendations to the corrections staff concerning the offender's needs. In jail and prison prerelease situations, there are more incentives for the providers to reach in to the inmates, as the inmate will soon be released into the community. This model may be more difficult to implement in some prisons which have a population covering a larger geographic area. However, some programs have found reach-in by telephone (case conferences) to be effective.

Third-Party Coordination

Third-party coordination can be a program model or a method of contracting for brokering and coordination of some or all services. It may be used with either of the models previously described (or a hybrid model that includes elements of both). When a third party is used, some coordination and case management functions are not performed by either the treatment provider or the individual responsible for supervision. Rather, an independent agency or program (such as TASC; see box below) serves as a liaison and is responsible for identifying transitional service needs, coordinating (not delivering) services, and matching offenders with these services. The

Model Third Party Entity: TASC

Treatment Alternatives for Safe Communities (TASC) serves to integrate the separate systems of criminal justice and substance use disorder treatment by identifying, assessing, and referring offenders to treatment as an alternative or supplement to justice system sanctions. TASC provides ongoing case management by monitoring the offender's compliance with justice system requirements and progress in treatment. TASC then reports that progress (or lack thereof) to the court or other supervision agency. TASC applies the leverage of the criminal justice system to encourage retention and progress in treatment. By establishing structured relationships within and between the treatment and justice systems and providing direct accountability to the court, TASC ensures ongoing support and effective communication between treatment providers and justice system professionals. The TASC "organizational elements" provide a framework for effective program configuration, support for treatment to retain offenders in programs and maintain client motivation, and support for the justice system to have effective and meaningful options that meet criminal justice goals and ensure public safety. TASC "operational elements" inform meaningful and effective sentencing decisions and ensure the implementation of individually tailored sentences that involve both treatment and sanctions. TASC's system of assessment, referral to treatment, and case management ensures that the powers of the legal system are utilized to reduce both the drug use and criminal activity of drug-involved offenders. TASC is a model that can be adapted to support corrections, the courts, including drug courts, and treatment agencies. It has had success in demonstrating increased treatment retention for offender clients, as well as improved communication and coordination among criminal justice and substance use disorder authorities.

third party may be from either the public or private sector. It may be particularly useful to broker for services in this way in more complex systems. Third-party models are more likely to be helpful in coordinating large systems, including multiple programs and services.

Key components

Rather than merely tracking the offender, the third-party contractor can provide continuous, ongoing case management to ensure that the offender enters and remains in appropriate treatment. For example, the third party may be responsible for moving the offender out of a treatment situation that is not working. This entity answers to both supervision and treatment authorities and is responsible for reporting on the offender's progress to multiple agencies, such as the court and parole authority.

When is use of a third party most effective?

Based on clinical experience, the Consensus Panel has concluded that a third party can be most useful when there are fragmented, disjointed services, making it difficult for either the institution or the community program to coordinate care. This approach to coordination of services is effective in filling gaps when case management services are not available, when there are no services within the institution to do transitional planning, and when little or no community supervision is available.

An Integrated Transition Approach

Although each program model has its strengths, transition planning ideally involves both institution and community services in a "mixed model." Such an integrated approach provides opportunities for effective collaboration and more readily unites systems because they are forming an alliance to reach mutual goals. The systems gain a greater understanding of each other, learn a common terminology, and develop trust in each other's work.

When systems integrate their functions to provide transitional services, there is enhanced preparation for those offenders who are being released from jail. Critical service needs are more easily identified, and the offender has a better opportunity to become engaged in community treatment. Relapse prevention efforts are more likely to succeed. Additionally, the mixed model allows systems to be more responsive to critical incidents, because monitoring and surveillance are more coordinated, there is better communication across systems, and sanctions are developed and enforced by both the criminal justice and substance use disorder treatment agencies.

Model Integrated Program: Federal Bureau of Prisons

The Federal Bureau of Prisons residential substance use disorder treatment program is the flagship of the Bureau's treatment strategy. Currently, 42 Bureau of Prisons institutions operate residential treatment programs, with a combined annual capacity of nearly 6,000 inmates. The programs are 6, 9, or 12 months long and provide a minimum of 500 hours of treatment. The Bureau has a three-phase treatment curriculum that is followed in every residential program. The third phase of this treatment is the beginning of the inmate's transition from the program.

The Bureau places tremendous emphasis on the transition component. Ordinarily, residential substance use disorder treatment graduates are transferred to a Bureau Community Corrections Center to complete their term of custody. These inmates participate in transitional treatment services, provided by community-based treatment providers and monitored by Bureau Transition Services Managers. Inmates who fail to successfully complete the transitional treatment program may be returned to secure custody for the remainder of their sentence.

Model Integrated Program: Phoenix House, New York

Phoenix House in New York is an example of the private and public sectors collaborating to offer a full continuum of treatment services for drug offenders. Since 1990, the Phoenix House/Marcy program has provided a continuum of care for drug offenders under contract with the New York Department of Correctional Services and with funding from the State Office of Alcoholism and Substance Abuse Services.

Beginning with treatment at the Marcy Correctional Facility in Utica, the first phase of this continuum provides a 6-month therapeutic community for 200 inmates from New York City in a specialized segregated facility. This phase is followed with up to 6 months of residential treatment in a community-based facility in the Bronx and/or participation in an outpatient treatment program based in Manhattan. Services provided include a modified therapeutic community structure and job functions, group and individual substance use disorder counseling, community meetings, house meetings, educational services, vocational/employment training, family support counseling, and Alcoholics Anonymous and Narcotics Anonymous.

Once offenders are paroled, they become voluntary clients unless parole stipulates continued treatment. The vast majority of these clients stay in treatment until graduation.

2 Case Management and Accountability

Coordinating systems to help the newly released offender can seem overwhelming, due in large part to the burgeoning caseloads carried by public sector agencies. Not only are the criminal justice and substance use disorder treatment systems fragmented and sprawling, but the offender will likely need ancillary services as well (discussed in Chapter 5), which calls for case management. As discussed in Chapter 1, case management can follow an outreach, reach-in, or third-party approach, or some combination of the three. No matter what the model, research shows cost benefits, through reduced recidivism, of cross-system integration for offender transitional services (Inciardi, 1996; Abt Associates, 1995; Swartz et al., 1996).

Case management is the function that links the offender with appropriate resources, tracks progress, reports information to supervisors, and monitors conditions imposed by the supervising agency. These activities take place within the context of an ongoing relationship with the client. The goal of case management is *continuity of treatment*, which, for the offender in transition, can be defined as the ongoing assessment and identification of needs and the provision of treatment without gaps in services or supervision. Accountability is an important element of a transition plan, and case management includes coordinating the use of sanctions among the criminal justice, substance use disorder treatment, and possibly other systems.

Case Management in Transition Planning

Ideally, case management activities should begin in the institution before release and continue without interruption throughout the transition period and into the community. It is recommended that transition planning begin at least 90 days before release from jail or prison. Early initiation of transition planning is important because it establishes a long-term, consistent treatment process from institution to community that increases the likelihood of positive outcomes. The case manager's communication with other transition team members at an early stage supports all aspects of the offender's recovery and rehabilitation (e.g., education, health, vocational training).

Ideal Array of Services

Certain services are integral to a substance-using offender's successful transition to the community. Reassessments should be conducted at various stages throughout the incarceration and community release process. Similarly, offenders also need continued supervision after institution release. Continued supervision also includes ongoing monitoring and assessment of the offender's needs. These periodic substance use disorder and supervision assessments should form the basis for ongoing case management and service delivery. However, additional assistance is needed in a number of areas prior to and after release to prepare the offender for the return to family, employment, and the community.

Often the offender needs help finding housing, since family and social support networks and financial resources may be minimal. Other activities may include teaching basic life skills such as budgeting, using public transportation, seeking and maintaining employment, and parenting. Many offenders have a history of job instability, unemployment, or underemployment. Improving the clients' likelihood of obtaining a job through general equivalency diploma (GED) preparation, enrollment in an educational program, vocational training, or job-seeking skills class increases their chances of success after release.

Many offenders need training to enhance interpersonal skills in both family relationships and with peers. Training in anger management and in parenting groups can provide new methods for resolving conflicts and facilitating reintegration into the family and community. If possible, the family should be involved in case management and treatment services during the transition to the community. Participation in self-help groups is an important adjunct to substance use disorder treatment to engage the offender in the larger peer support community.

The array of services identified reflects the multiple psychosocial needs of offenders, and takes into account the likelihood that offenders will have periods of backsliding requiring more intensive levels of treatment and supervision.

An effective transition plan is dynamic and evolves as the offender accepts greater responsibility. The offender should be present at team meetings so that she can see accountability modeled as she participates with team members in implementing the plan in the community. Being a part of the planning process helps offenders begin to make their own decisions and take responsibility for themselves. Because of the clear system of sanctions and rewards, a sense of accountability is reinforced.

The Role of the Case Manager

Continuity of care implies that the range of services needed by offenders are received, regardless of the system. When the correctional system and the treatment system collaborate effectively, there is an increased likelihood of treatment success and a reduction in the risk of relapse and future criminal behavior.

Case management is a critical element underlying continuity of care. Studies indicate that case management improves shorter term outcomes of treatment for substance use disorders (Shwartz et al., 1997). The case manager(s) links the offender with necessary resources, tracks progress, reports information to supervisors, and monitors conditions imposed by the court. Systems differ widely in terms of which entity provides case management services, but the necessary functions are the same, whether this role is filled by one person, an interagency team, or a separate agency. The case manager works directly with the client and collaborates with other criminal justice and treatment provider representatives to ensure that the offender maintains abstinence and avoids reoffending.

Case management functions typically include the following activities:

- Assessing an offender's needs and ability to remain substance- and crime-free
- Planning for treatment services and other criminal justice obligations
- Maintaining contact with the probation officer and other criminal justice officials
- Brokering treatment and other services for the offender
- Monitoring and reporting progress to other transition team members

- Providing client support and helping the offender with all involved systems (i.e., treatment, criminal justice, and child welfare)
- Monitoring urinalysis, breath analysis, or other chemical testing for substance use
- Protecting the confidentiality of clients and treatment records consistent with Federal and State regulations regarding right to privacy (42 Code of Federal Regulations [C.F.R.], Part 2)

Staff members of the program Treatment Alternatives for Safe Communities (TASC) begin case management services for the offender as early as local jurisdictions permit—pretrial, presentence, postadjudication, or prerelease (Weinman, 1992). In a model program in Hillsborough County, Florida, a TASC counselor is assigned to each offender and conducts an intake assessment for the community agency (Department of Justice, 1991). A plan used in Ohio calls for case management activities weeks or even months prior to release, to set the stage for successful reintegration in the community and to develop necessary linkages (Ohio Department of Alcohol and Drug Addiction Services and Ohio Department of Rehabilitation and Correction, 1997).

It is optimal to have a single, full-time case manager working in conjunction with a transition team of highly involved staff members from both systems. However, if the infrastructure and resources do not allow for a full-time case manager position, the primary counselor working with the offender should take the lead in providing these functions. In these cases, the Consensus Panel recommends that this role be filled by the treatment provider. As the provider has clinical and personal knowledge of the client, he can make appropriate referrals for ancillary services, such as employment, vocational training, medical treatment, and support for strengthening family relationships.

The increase in the use of the term *boundary spanner* to describe part of the function of a case manager underscores the fact that all organizations have boundaries. In social service systems, those lines are often unclear because of overlapping functions or gaps in functions. To avoid the fragmentation of care that often results from uncoordinated systems, the Consensus Panel recommends that a case manager or boundary spanner become the primary link between the offender and all necessary social services. The Panel recommends that the boundary spanner come from the community-based treatment program, or the supervising agency, though she may have a different "base" agency, depending on funding and other variables.

Ideally, the case manager assumes primary responsibility for identifying resources and helping the offender learn how to access them. The case manager's duties include clear, concise, and accurate documentation of the offender's progress, including development of transition plans, legal status, program protocols, and assessment results. This information should be shared with the treatment providers, supervising criminal justice agency, and other systems partners, as appropriate, who are collaborating on activities related to the offender's transition plan. The case manager needs a broad, in-depth knowledge of the programs, modalities, and services of the providers in the community to ensure an appropriate match for the offender.

Based on the assessment, the case manager should have the authority to make recommendations to the community supervision officer about the most appropriate treatment options. This is particularly true if there was originally a mismatch between the client's needs and the placement decision. It is important for the case manager to determine and document the reasons for transfer when the offender changes programs. Information on success and failure rates of placements can be useful when making future referrals.

The Concept of the "Boundary Spanner"

During site visits to jail mental health programs, one study noted that the most effective programs included a core staff position of boundary spanner. This person managed interactions among correctional, mental health, and judicial staff and enhanced the program regardless of the incarceration setting (Steadman, 1992). The boundary spanner interacted on a daily basis with representatives from all systems, and negotiated among these three (often competing) systems.

A boundary spanner is especially useful for offenders in transition to the community, and should be able to address different sets of legal, clinical, and social issues that arise at different points in the criminal justice system. Depending on the point in the system(s) where the offender is found, an entirely different set of legal, clinical, and social issues arise, and the boundary spanner should have the capacity to address them all.

Boundary spanners must manage the sometimes conflicting interests of many organizations. Therefore, those who perform this function should have an in-depth knowledge of the systems with which they interact, which may require some years of experience. Individuals who perform well in this role know both the formal and informal norms of the organizations, as well as their internal operations and politics (Steadman, 1992). Boundary spanners must be respected and have credibility from all the organizations with which they interact. In an ideal situation, the system supports the boundary spanner with a full-time position that pays a reasonable salary. The job title and pay should be based on the functions performed, rather than on professional degrees. It may be helpful to conceptualize the boundary spanner in the context of the provision of case management. Although many systems find difficulty in financially supporting such a role, the function of the boundary spanner is a useful model that may be adaptable in local jurisdictions.

Transition Plan Elements

Responsibility for continuity of treatment and offender accountability will be shared across systems. Below are elements that should be part of the transition plan.

Ongoing Comprehensive Assessments

The Consensus Panel recommends the development or identification and use of standardized, comprehensive risk and need assessment tools appropriate to offender populations. Offenders should be assessed as early as possible and throughout their involvement in the correctional system. Risk assessments done at the time of release help determine the appropriate level of supervision in the community (e.g., parole, postprison supervision). Needs assessments determine and document the offender's medical, psychiatric, psychosocial, and family circumstances, and help identify the appropriate level of treatment. Since the treatment needs of addicted offenders change over time, there is a need for periodic, updated risk and need assessments. Ideally, assessment information is part of a cumulative and automated assessment management system.

Multiple assessments of offenders with substance use disorders are necessary and should examine

- **Treatment Needs**—to determine what types of treatment interventions, services, and programs are appropriate
- **Treatment Readiness**—to evaluate the extent to which clients are motivated for treatment

and whether they are likely to benefit from treatment
- **Treatment Planning**—to determine how intensive the treatment should be and on which areas it should focus
- **Treatment Progress**—to periodically determine whether clients are responding to treatment and whether treatment should be modified
- **Treatment Outcome**—to determine the extent of behavioral change, success, or failure (Inciardi, 1993)

Assessment for substance use disorders

Assessment for substance use disorders is central, since it helps determine the level of treatment services and type of treatment that can best meet the offender's needs. It may also help identify barriers to treatment.

Assessments should be standardized, following accepted clinical protocols such as the Substance Abuse Subtle Screening Inventory (SASSI), the placement criteria of the American Society of Addiction Medicine (ASAM), and the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Since many factors associated with an offender's criminality will impact on his treatment needs, wherever possible relevant information from the risk assessment should be considered in evaluating the substance use disorder assessment. In New York State, the Division of Probation and Correctional Alternatives is working with the Office of Alcoholism and Substance Abuse Services to create a uniform assessment protocol for use across the criminal justice continuum, which addresses related risk elements in the substance use disorder assessment of the criminally involved client.

The substance use disorder assessment can be conducted by institutional treatment staff or by community program staff that comes into the institution or on site at the community program. Staff members conducting assessments should be clinically trained and meet the licensing or certification requirements of the jurisdiction. If an assessment is being conducted by a community-based treatment provider, it is vital that the offender's complete treatment records be made available to the treatment provider. The Consensus Panel recommends that assessments for inmates be conducted at entry to the institution and 3 to 6 months before release, at a minimum. Prerelease assessments increase opportunities for the offender to prepare for transition and allow institutional transition personnel and community providers to plan for the offender's entry into a program. Careful planning of assessments across points in the criminal justice system can help avoid duplication of effort and resources, preventing different parts of the system from unnecessarily repeating assessments.

While there are different models for conducting assessments of offenders in prisons, the process ideally is conducted through a multidisciplinary team approach. For example, in one approach, the institutional treatment staff provides a treatment summary and referral form for offenders who are in custody at a halfway house and participating in community-based treatment. In another approach, the community-based treatment provider conducts the assessment in the prison. Yet another approach has the offender, the corrections staff, the parole officer, and the community treatment provider all contributing assessment information.

Assessment of life skills

When offenders leave institutional treatment, they are often thrust into environments that feel utterly unfamiliar. Some say they feel like tourists in a culture they don't understand, with foreign rules and expectations. Offenders who have been in prison for several years may become disoriented and highly stressed and thus require counseling, while others may only need training in a few basic life skills. It is important for the case manager as well as the community treatment provider to understand the level of psychopathology that may be directly related to the duration of the incarceration.

Offenders often have significant needs for basic life skills such as managing the tasks of everyday living, responding to people who have biases about them, and coming to terms with societal norms and expectations. Case managers must ensure that these needs are met, since many offenders are easily frustrated. Therefore, assessments of offenders' overall skills for daily living should be conducted. For descriptions of various assessment methods, please refer to the TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998b).

The goals of assessments are to determine specific strengths and weaknesses and to locate opportunities for improvement in order to reduce the propensity for relapse. Critical areas to be assessed include stress management skills, general psychosocial skills, emotional readiness for the transition, and money management abilities. Other areas to assess are problem-solving abilities, decisionmaking, and other cognitive behavioral skills.

A case management assessment should include a review of the following functional areas. These items are not exhaustive, but demonstrate some of the major skill and service need areas that should be explored. The assessment of these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. The case manager may have to perform many services on behalf of the client until skills can be mastered.

Personal living skills

The client's ability to perform basic self-care functions and to meet personal needs is a critical element in a case management assessment. Individuals with deficits in this area are most likely to have serious cognitive deficits and are also likely to have coexisting severe mental disorders or neurocognitive deficits secondary to trauma and/or substance use. The client should be assessed for ability to perform the following activities of daily living:

- Personal hygiene and grooming
- Management of sleep/wake cycles
- Dressing, taking care of clothing
- Preparing basic meals or obtaining a nutritious diet
- Faithful and correct use of prescribed medications
- Money management
- Orientation and sensitivity to time

Social and interpersonal skills

Effective participation in the self-help groups often required of those with substance use disorders requires some level of social ability. The case management assessment should therefore include an evaluation of the client's

- Conversational skills
- Respect and concern for others
- Appropriateness in varied social settings
- Attachments, ability to form and sustain friendships and relationships
- Constructive leisure and recreational activities
- Anger and conflict management
- Impulse management
- Criminality and distorted thinking

Service procurement skills

While the focus of case management is to assist clients in accessing social services, the goal is for clients to learn how to obtain those services. The client should thus be assessed for

- Ability to obtain and follow through on medical services
- Ability to apply for benefits
- Ability to obtain and maintain safe housing
- Skill in using social service agencies
- Skill in accessing mental health and substance use disorder treatment services

Prevocational and vocation-related skills

In order to reach the ultimate goal of self-supported independence, clients must also have vocational skills and should therefore be assessed for

- Basic reading and writing skills
- Skills in following instructions
- Transportation skills
- Manner of dealing with supervisors
- Timeliness, punctuality
- Telephone skills

The case management assessment should include at least a brief scan for indications of harm to self or others. The greater the deficits in social and interpersonal skills, the greater the likelihood of harm to self and/or others as well as endangerment from others. The case manager should also conduct an examination of criminal records. If the client is under the supervision of a criminal justice agency, supervision officers should be contacted to determine whether or not there is a potential for violent behavior, and to elicit support should a crisis erupt.

Assessment of literacy and employment

Assessment of literacy skills is another key component of the transition. Ideally, an offender who needs basic literacy training will have received it while incarcerated. Many institutions that have experienced funding reductions have successfully turned to local boards of education for funding or attracted volunteers to work with inmates. However, in many jurisdictions, the responsibility for literacy training has shifted to the community because of reduced funding for educational programs in prisons. Literacy training helps increase an offender's self-confidence in participating in society and dramatically increases the ability to seek and obtain employment. Offenders should receive training in other aspects of job readiness as well. They will likely need help with resume writing, interviewing techniques, and various reentry issues related to employment.

There are differences among States and systems with regard to employment following release. Sometimes offenders are required to begin work almost immediately (for example, within 2 weeks after release from prison). Absent such a requirement, however, an assessment of the relative priority of return to employment and treatment may determine that the latter is actually a higher priority. In such situations, the offender can address treatment needs while preparing for a return to employment. If the offender's emotional readiness to return to work is poor, the offender also can be provided with services (e.g., self-help and empowerment workshops, job readiness and skills training, mentoring).

Placement in an Appropriate Treatment Setting

Placement of the offender in a treatment program should be clinically appropriate and based on the results of risk and needs assessments. In an ideal transition, the offender participates in treatment planning and "buys in" to the program, internalizing accountability. Examples of appropriate treatment settings include a licensed residential treatment facility, a residential program with a licensed substance use disorder component, a licensed intensive outpatient substance use disorder program, a standard outpatient treatment program, a substance use disorder awareness and education program, and an aftercare program. Placement planning may also include linkages with and arrangements for participation in local self-help groups, including information on times and locations of meetings or obtaining a sponsor.

The placement should reflect the risk presented by the offender, that is, the level of responsibility and accountability that can be attributed to the offender. For example, a residential program provides a higher degree of accountability than an outpatient program. As an offender internalizes an accountability structure with the support of the treatment provider and the community supervision officer, he can be placed in a less controlled environment. Eventually, the community supervision officer may leave the transition team, and the offender may be supported only by the treatment provider. In some cases, however, community supervision may extend beyond the formalized treatment plan, and the offender will exit treatment and still be accountable to a legally mandated and enforceable period of supervision.

Relapse Prevention Plan

An individualized relapse prevention plan should be developed for each offender. This plan, which can be brief, generally lists the behavioral "early warning" signs that can be useful signals to all members of the transition team. It is often developed as a standard form, written in simple, nonclinical language, with a checklist of indicators that help predict the potential for relapse. Examples of effective relapse prevention plans and their components are reviewed in the CSAT publication, *Relapse Prevention and the Substance-Abusing Criminal Offender* (CSAT, 1993a).

According to Peters and Dolente, relapse prevention concepts are easily understood by inmates, who generally have the ability to learn why prior attempts to stop using drugs were unsuccessful and to anticipate situations that threaten recovery (Peters and Dolente, 1993). An effective relapse prevention plan involves self-help groups and peer support, as well as the community treatment and criminal justice systems.

Duration of Treatment

Since offenders with substance use disorders have a chronic, relapsing disorder, a treatment plan must be of appropriate intensity and duration. Findings of studies of the Amity Prison program in San Diego, the Key-Crest program in Delaware, and the Stay'N Out program in New York demonstrate that longer duration of treatment—of up to 1 year—is consistently associated with better treatment outcomes among prison inmates (Lipton, 1995). The Amity program includes a 1-year residential aftercare component. The optimal duration for prison populations has typically been found to be 9-12 months. Recent findings of a Key-Crest study indicate that a longer and more comprehensive regimen of treatment increases the likelihood that an offender will be substance- and arrest-free in the long run (Inciardi et al., 1996). Findings from the Shwartz study previously cited, which describe outcomes from jail treatment to community treatment, indicate that outcome improves when the course of treatment is at least 30 to 90 days, followed by continuing community treatment. These results provide clear support for a comprehensive approach that includes jail or prison treatment followed by community aftercare for offenders with histories of substance use disorder problems.

Support Services

The psychosocial and substance use disorder assessments described above will help pinpoint offenders' needs for social services. Offenders may need help obtaining social services, especially in light of recent changes in welfare reform. They should receive, at the very least, up-to-date social resource and referral materials. Support services are discussed in greater detail in Chapter 5.

Depending on the capabilities of offenders, the case manager may need to be assertive in providing assistance, for example by helping offenders keep appointments, perhaps even by driving them to their appointment sites. However, the ultimate goal of treatment during the transition is to promote offender self-

Model Program: Women in Community Service (WICS)

WICS is a national nonprofit organization founded in 1964 in conjunction with the Job Corps. WICS consists of a consortium of women's groups that began a mentorship program which has evolved into a life skills program as well. Although not originally designed for offenders, the Shelby County (Memphis, Tennessee) Division of Corrections and the Oregon Department of Corrections have WICS programs for women inmates. These programs include a 10-week job readiness/life management program along with mentors from the community, many of whom are professionals or managers. In a recent outcome study, women offenders who participated in WICS were better able to find work and stay out of prison.

Source: Jolin, 1998.

sufficiency. Though case managers may have to broker services initially, they should encourage self-sufficiency by having offenders secure services themselves.

Transitional housing

Research demonstrates that extensive residential treatment following release or as an alternative to incarceration can reduce the rates of rearrest and relapse and increase the rate of employment (Martin et al., 1995; Hiller et al., 1996). This suggests that appropriate housing is an important aspect of positive treatment outcomes. A basic requirement for a successful transition is access to housing that is safe, free of substance use, provides a structured environment, and supports treatment goals. When offenders enter a residential treatment program, such as a therapeutic community, their housing needs and treatment needs will be met simultaneously. Another option for offenders is going to a halfway house and working in a furlough program.

Mentors and role models

Mentoring is an age-old practice that fosters growth and independence, often for the mentor as well as the person mentored. The case manager or specific service provider can develop and implement mentoring services to help promote successful reentry into the community. Currently used primarily with women and youth, mentoring services involve an individual outside the criminal justice system who provides personal support to the offender to help her access community resources and to provide social support. In this context, mentoring can help offenders raise their expectations and hone skills like problem solving and interacting with people.

In some mentoring programs, the mentors meet with offenders while they are still incarcerated and encourage them to set concrete goals, such as finding jobs, obtaining social services, and finding housing. Typically, the mentor is a nonprofessional who listens, provides support, and provides encouragement for life skills development.

Exoffenders who are no longer in the criminal justice system and have successfully navigated life in the community can become important role models in the lives of transitional offenders as volunteers. They can help by driving offenders to treatment, bringing them to social service appointments, helping them prepare for job interviews, sitting in on assessments with them, and accompanying them to 12-Step meetings and peer support group meetings. Both staff members and volunteers can serve as role models. The Fortune Society in New York City, for example, provides counseling, education, alternatives to incarceration, career development, substance use disorder treatment, AIDS/HIV counseling, education, and referrals to offenders. The

Figure 2-1

Indicators of Treatment Success

- **Reductions in substance use, extended periods of abstinence, substance-free days, crime-free days, reductions in the number of arrests**
- Restoration or establishment of ongoing and recovery-supporting social network
- Substance-free and crime-free for at least a year
- Consistent employment
- Stable housing
- Bank account with savings
- Agreed-upon treatment goals met
- Consistent participation in support groups
- Correctional obligations (terms and conditions) met
- Restitution (fines and fees) paid

counselors at the Fortune Society are exoffenders or recovering substance users and serve as role models, tutors, teachers, and therapists. (See Chapter 6 for more on this program.)

Self-help groups

In addition to developing other role model concepts in treatment programming, transitional programs can encourage interaction with 12-Step programs, Rational Recovery, Project Smart, Winner's Circle, and other self-help programs. In self-help groups, sponsors generally mentor newer members.

When offenders participate in self-help programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) during incarceration, they learn to talk openly about substance-use-related challenges and successes in an emotionally safe environment. These self-help meetings take place throughout the country and are often connected with community treatment programs. As a result, offenders who participate in self-help groups in institutions have a ready-made and familiar source of support in the community. When members of the 12-Step community go to institutions and run 12-Step meetings, they provide personal linkages to the community and to other 12-Step groups in the community.

Participation in 12-Step groups provides peer support for remaining abstinent, handling daily living problems, and developing a healthy social network. In addition, the self-help approaches and methods work well in combination with treatment: 12-Step milestones can be used as treatment objectives; educational sessions can incorporate the 12 Steps, and 12-Step philosophies can be incorporated into the overall treatment process. At the Interventions-Wilmer program, for example, the eighth step, "making amends," is incorporated into the final 3 months of treatment (Barthwell et al., 1995). Institution and community programs can support the 12-Step process by providing the space for AA and NA meetings on site. Under the Bridging the Gap Program in New York City, inmates receive and send letters to AA members in the community. Weeks before release, they are given the times and locations of AA meetings in their home community, and may even be met and taken to their first AA meeting on the day of release.

In addition to 12-Step programs, other self-help groups can contribute to successful transitions. Winner's Community is a developing national network of successfully recovering exoffenders. This program has created a prosocial community among graduates of therapeutic community (TC) and other substance use disorder treatment programs.

Winner's Community, which encourages honesty, a work ethic, personal accountability, economic self-reliance, caring/concern for others, family responsibility, community involvement, and good citizenship, operates both in the institution and in the community (De Leon, 1995). The therapeutic peer support network in the community is called Winner's Circle; members engage in frequent community meetings and activities. Winner Circle is the institution-based meeting for offenders participating in drug treatment in prisons and jails, preparing offenders for the challenges on the outside when they are released. This gives transitioning offenders a ready support network upon release.

Family involvement

Many offenders do not have intact or available families, and many offenders' families pose a risk for substance use or recidivism. Nevertheless, if they can provide positive support for the goals of the treatment, family members should be involved in the assessment, planning, and treatment of transitioning offenders.

Ideally, family education efforts should occur before the release of the offender. Significant others and family members should receive information about what to expect when the offender makes the transition to the community. They should also understand the nature of the treatment program in the incarcerated setting, the substance use disorder, the transition plan, and resources for the offender and the family. If appropriate, family members may be asked to provide collateral information about the offender's situation, but offenders should always be asked if they want their families involved in their treatment and give formal consent.

If assessment and treatment planning meetings are conducted in residential treatment or halfway houses, family members can sometimes participate in meetings and meet with parole officers. Some prisons permit family members to participate in prison-based meetings prior to the offenders' release. In fact, some prisons allow extra family visits contingent on the family's willingness to participate in treatment meetings.

To be a positive support for the offender and to participate in the reintegration process, family members may benefit from social and self-help resources, such as Al-Anon and Toughlove groups. Another support group is Prison Families Anonymous, for families with members who have been involved in the corrections system. This valuable resource can address such issues as guilt, responsibility, owning one's behavior, detachment, and control. This group also has a referral service to help families locate other resources.

Model Program: Providence House

Providence House in New York is a sanctuary of six transitional homes committed to providing drug-free shelter and support to homeless, abused, and formerly incarcerated women and their children in a hospitable, compassionate, and communal atmosphere. Volunteers who work outside the houses live permanently in the houses, creating a core community, providing stability and supervision. In addition, trained staff members provide case management within the homes.

Model Program: WomenCare, Inc.

WomenCare, Inc., is a private not-for-profit mentoring program in New York City that recruits and trains volunteer mentors to help women released from prison adjust to life outside. Mentors receive ongoing training emphasizing problem-solving techniques and skills to enable the offender to take personal responsibility and make independent life decisions. Three months before an offender's discharge, a mentor begins visiting the incarcerated woman to formulate realistic goals and mutual expectations. On the day of the discharge, the mentor is waiting for the offender to help her make the initial transition to the community. The mentor can offer moral support and concrete help. WomenCare has a working relationship with more than 80 service providers assisting in areas dealing with housing, employment, treatment, health, parenting, legal assistance, and education.

Fostering Accountability

Offender accountability is demonstrated by responsible behavior that helps an offender build a crime-free and substance-free lifestyle. It includes the fulfillment of commitments to legal authorities, to the substance use disorder treatment plan, the community, and to oneself. Accountability develops when an offender internalizes the structure learned within a program and applies it to life after incarceration—following rules, adapting to a work culture, and adopting community norms. When an offender demonstrates the need for fewer external controls on his behavior and less supervision, he is rewarded with more life choices and greater freedom.

Four interlocking components can help ensure offender accountability and continuity of care during transition from incarceration to the community. They are criminal justice supervision, sanctions for violations, rewards for progress, and treatment with ancillary services.

Community Supervision

Offenders with substance use disorders should have some form of community supervision stipulated upon release to help maintain treatment progress. However, some States cannot stipulate the continuation of treatment upon release. In the State of California, for example, an offender has a right to challenge parole recommendations and reject substance use disorder counseling, even if recommended by a transition team or parole officer. In most cases, however, mandated treatment supports the work of the transition team by lending the authority of law.

The Use of Incentives and Sanctions

The use of incentives and sanctions is an integral part of community supervision, although sanctions are generally less powerful than incentives in changing behavior (Gendreau, 1996). However, sanctions are often essential in fostering accountability in offenders.

Sanctions, or responses to noncompliant offender behaviors, help hold offenders accountable and protect public safety. Offenders should be told exactly which sanctions will be used in response to particular noncompliant behaviors at orientation. Sanctions are most effective when applied in a graduated or "tourniquet" manner. Appropriate sanctions include either punitive or supervision-oriented responses (such as increased urine testing) as well as therapeutic responses (such as increased treatment level). Effective sanctions are matched to specific behaviors by severity. For instance, the first missed appointment should not result in a return to prison, but a fourth "dirty urine" calls for more than a verbal warning. Finally, the parties responsible for services to the offender should be involved in applying sanctions. In other words, sanctions are most effective when applied by a team approach.

Innovative and creative sanctions should be developed to address violations. The methods used should be understood and agreed upon in advance by both substance use disorder treatment and community supervision staff. Sanctions should be swift and certain or the credibility of the system and accountability are greatly reduced. On the other hand, the sanction system should include a mechanism to lessen the intensity of requirements for those making measurable progress in both the legal and treatment requirements.

Examples of sanctions typically provided by the criminal justice and the treatment agencies are shown in Figure 2-3.

Periodic Reviews of the Offender's Progress

The transition team should conduct periodic reviews of the issues addressed by the transition plan, including legal requirements, appropriate placement in a level of care, the effectiveness of sanctions, and the extent to which the offender is meeting expectations. Risk and needs assessments can help determine the level of supervision required.

During periodic assessments, supervisors should look at concrete measures of accountability, such as a progress report detailing treatment attendance and progress, and patterns of relapse and urinalysis results. A protocol should be established to make urinalysis an accountability tool that can be used randomly, for cause, and by program design throughout the transition period. A baseline urine test should be administered on the first visit to the criminal justice authority after release. The results can then be used as a measure against subsequent tests.

Violations of any aspect of the transition plan must be dealt with consistently, appropriately, and in a timely manner. A lax attitude will jeopardize the individual offender's accountability, as well as public safety and the integrity of the program. In some cases, the decision must be made for offenders to return to prison or jail. The case management team must

Figure 2-2

Benefits of AA

A comprehensive review of the research on AA reveals several important findings:

- Research shows a strong association between AA participation that occurs during or following professional treatment and both reduced drinking and abstinence.
- Research suggests a strong association between increased frequency in attending AA meetings and improvements in drinking behavior measures, such as abstinence and decreases in alcohol consumption.
- Research suggests a modest association between increased participation in and affiliation with AA (such as obtaining or becoming a sponsor) and improvements in drinking behavior measures, such as abstinence, decreased drinking, and decreased relapse.
- Research suggests modest associations between AA participation and improvements in several areas of psychosocial functioning.

Source: Landry, in press.

Figure 2-3
Commonly Used Sanctions

- Increased number of urinalyses
- Breathalyzer™
- More frequent contacts
- More frequent appointments
- Curfew
- Extension of term or time
- Community service
- Increased AA and/or NA meetings
- Withholding of privileges and personal freedoms
- Day reporting
- Electronic monitoring
- Facility transfer
- Increased intensity of treatment
- Brief reincarceration
- Additional reporting with additional charges or costs assessed
- Return to incarceration, i.e., supervision violation

continually balance the conflicting needs of flexibility through individualized treatment planning with the consistency needed for personal accountability, treatment integrity, and public safety.

Discharge and Safety Issues

Treatment discharge must be planned with community safety as a central issue, and criminal justice discharge procedures are determined by law. However, criminal justice and treatment staff can work closely together on discharge and related issues until termination of supervision. A discharge team should include someone from the releasing institution, a community supervision officer, a treatment provider, and, if available, the case manager. The treatment discharge summary is completed by the treatment provider.

Treatment staff receives information on compliance from criminal justice staff who, in turn, is informed of treatment progress. If the offender commits a technical violation after discharge, supervision may be extended, even if the infraction is not substance related. Any behavior issue is also considered a treatment issue. Depending on the type of discharge required by law or recommended by the treatment provider, an offender should always be made aware that treatment is available.

The length of stay in the program should be determined by the treatment provider who, along with the community supervision officer, can monitor the progress of the offender. In some cases, the treatment phase may end, but a criminal justice agency maintains supervision authority over the offender. In those cases, if a treatment reinoculation is needed, the mechanism for it should be built into the system.

States should consider developing jail and prison diversion programs as graduated and intermediate sanctions for technical violators so that the offender can move from community-based treatment back to short-term services, maintaining continuity of care. A complementary system of incentives can also help prevent violations by rewarding and encouraging accomplishments and achievements. Programs of this nature can help decrease criminal activity, ensure continuation of treatment, and prevent relapse. For example, the Stay'N Out program at the Arthur Kill Correctional Facility at Staten Island, New York, has a special relapse prevention program. The Amity Program at the Richard J. Donovan Facility uses a 30-day "dry-out" prison program as an intermediate sanction. The Willard Drug Treatment Campus in New York State provides parole violators with an opportunity to enter a 90-day corrections-based treatment program without returning to jail or prison.

The Transition Planning Process

Successful transition from criminal justice institutions to community treatment is almost always the result of purposeful and careful planning. This planning must take place at both the State level and institution level for prisons, as well as the many agencies and programs involved in the transition. Coordinating information exchange and training will produce a more efficient and efficacious planning process. This transition or follow up planning is required by the various standards of correctional health care. In the National Commission on Correctional Health Care standards, for example, the issues are addressed under a separate continuity of care section.

The Flow of Information

The transition team should clarify the sources of information necessary for the transition plan. For example, interagency and intersystem agreements should be clearly defined early in the planning process so that roles, responsibilities, and policies can be clarified; confidentiality issues can be addressed; and means of covering treatment costs can be identified. Once confidentiality issues are addressed, data maintained in management information systems (MIS) can be shared to promote interagency communication, increasing the likelihood of successful transitions. An MIS can provide rapid access to information across agency lines.

The transition plan for an individual should increase the quality of information transferred from staff in the institution to providers in the community, decreasing problems caused by miscommunication about the offender between the community supervision officer and treatment staff.

Cross-Training

Parole officers, institution treatment providers, community treatment providers, and corrections release counselors should be cross-trained to improve appropriateness of placements. Cross-training builds trust and reduces conflicts between staff members from different systems.

Immersion training may also be an appropriate intervention that ensures better referrals and that fosters a systemwide understanding of the offender. The goal of immersion training is to provide an intense educational experience for all system representatives (judicial, corrections, probation, parole, clinicians, and other community representatives) about the transition process. The Texas Commission on Alcohol and Drug Abuse and the Texas Department of Criminal Justice provide immersion training to familiarize system representatives with their Criminal Justice Treatment Initiative, which provides different levels of treatment to inmates, parolees, and probationers. The Texas training is a 3-day session that includes role-playing and other interactive exercises to help increase the sensitivity of various players toward the offender's problems, obstacles, and challenges in transition from prison to the community.

What is learned through the training is invaluable, especially to the parole officer and community treatment providers who are in charge of supervising the offender at the riskiest points of this transition. Training provides insight into incidents that are likely to occur and issues that must be discussed with the offender. Other benefits include increased interagency understanding and cooperation, enhanced understanding of the roles of the various agencies and their staff members providing services for the continuum of care, interdisciplinary team building, increased awareness of the positive values of an effective transition program, and increased support for changing existing systems to facilitate transition more effectively.

3 Guidelines for Institution and Community Programs

Transition plans should be collaborations among providers both inside and outside the institution. For that reason, Chapter 2 outlined the elements of a treatment plan without specifying particular roles for institution and community providers. Although flexibility is key, treatment providers in the community will emphasize different aspects of transition planning. Transition planning also varies from institution to institution and for different types of offenders. This chapter provides guidelines tailored more specifically to providers on both sides of transition.

Reaching Out From the Institution

The focus of institution treatment should be preparation for continued treatment on the outside. The message to the offender is that this is the beginning of the treatment commitment, and that continuing care will be arranged upon release. Institution treatment emphasizes this readiness message in all treatment phases, underlining a strong motivational and relapse prevention message.

Ideally, the institution's treatment program is part of a system that includes community-based services, rather than disconnected from the community. The institution's program should strive to exemplify innovative treatment practices and obtain licensing from the State authority.

Treatment programs within prisons and jails can encourage participation of community programs in the transition process. However, prisons and jails by their nature limit outsiders' access to the institutions, making it a challenge for community-based social service and treatment providers to serve incarcerated people. However, institutions can be community-friendly and invite social service agencies into the institution to work directly with offenders being prepared for release. The community agencies could provide contact information and written literature about services to both staff and inmates. Community treatment providers that contract to deliver institution-based treatment are in an ideal position to also help with transition efforts. Similarly, corrections agencies can enlist contractors to provide case management and other transitional services.

One of the goals of the transition from institutional treatment to community-based treatment is to make better use of institutional treatment as a stepping stone to help offenders become self-sufficient, productive members of society. In the short term, the intent is to help offenders move from an institution-based treatment program to a community-based program with a minimum of disruption in services.

Special Considerations by Type of Incarceration and Population

Jails

Several differences between prisons and jails affect the way treatment services and transition to the community are delivered. The most significant is length of incarceration. Because jails are used as pretrial facilities for pending court actions, it is often unknown how long an offender will be held, making treatment planning difficult for many jailed offenders. The policy in some States is to provide substance use disorder treatment if the offender is sentenced to jail for 60 days or more.

It is difficult to maintain continuity of treatment in a jail setting, because offenders move in and out of court. Incarceration often creates a crisis that ripples throughout an offender's life, affecting family, legal, and other matters. Children may be placed outside the home, and offenders may be in the process of detoxification. Because jail experiences can cause instability on so many fronts, social service delivery and crisis management are especially important.

The Consensus Panel recommends that treatment be provided if a substance-using offender is scheduled for confinement in jail for a period of time sufficient to provide adequate treatment for the offenders' needs. Inmates with shorter sentences can be placed in alcohol and drug education or other treatment readiness programming. Results from a recent evaluation of the effectiveness of a jail-based treatment program suggested that optimal treatment length is a period of 3 to 5 months followed by immediate placement in a community treatment program (Swartz et al., 1996).

Despite the problems, treatment in jails has some advantages, especially for transition work. The Cook County Jail Day Reporting Center, for example, trains offenders in life skills. More than a dozen social service providers in the community staff the reporting center and conduct trainings on rites of passage, violence prevention, parenting, and relationships. This program also has a training program for offenders who are drug dealers but not drug users.

Jailed offenders often have opportunities to receive substance use disorder assessment and treatment planning from community providers who come into the jail. Assessment or treatment planning that prepares the inmate for more structured treatment on the outside has the benefit of priming the inmate for more intensive treatment in a controlled environment that provides for public safety. Treatment units in jails also have less infractions and violence than other units in the institution.

Furthermore, the sentencing decision may be affected if a local treatment provider involved in the pretrial or presentence phase determines that the offender has demonstrated a willingness to participate in the treatment process and develops a treatment plan. Judges may even consider treatment as an alternative to incarceration. This option provides a strong motivation for many offenders.

A number of studies have shown that treatment effects on recidivism do not appear before about 90 days of treatment, and that treatment effects improve with time in treatment (Hubbard et al., 1989; Simpson, 1981, 1984). Time in treatment, whether in the institution or in the community, is a critical factor. Because jail sentences tend to be short, good jail-to-community continuity of treatment is essential for a longer singular treatment episode. Thus, the Consensus Panel recommends that the shorter the jail program, the more obligation the

Model Program: Probation Detention Program

One potential model for other jurisdictions is found in the Wayne County, Michigan, Comprehensive Corrections Plan funded under the State's Community Corrections Act. The program, called the Probation Detention Program, serves both probation violators who would otherwise be sentenced to jail or prison and graduates of the State's boot camp program, the Sentencing Alternative to Incarceration Program (SAI). This program provides an example of the institution reaching out to a community program to arrange for transitional services. The program is centered at a facility that provides assessment, referral, and residential treatment. Failures are met with "swift and certain" sanctions. Specific services for each offender are determined by an individual risk/needs assessment and implemented by means of a subsequent individualized case management plan. Programming includes 10 areas: orientation and assessment, substance use disorder counseling, life skills counseling, education, employment preparation, vocational training, employment, community service, physical training, and cognitive skill training. The movement of offenders from one phase to another (incarceration to residential programming to community) includes reincarceration when appropriate.

program has to ensure continuity of service. Even inmates leaving jail without a community sentence should receive a community treatment referral. Likewise, if the offender is sentenced to prison, a treatment plan should follow the offender to the designated correctional institution. If funding is limited, local Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings can be supported in the jail several nights a week. Those incarcerated hear "leads" from previous offenders, find sponsors and mentors, and become less resistant to community-based treatment.

Prisons

In contrast to jails, prisons house offenders whose sentences are generally longer than 1 year. Since offenders will be in prison for a substantial period of time, many prison-based treatment programs are able to provide extended treatment. Research demonstrates that longer treatment length can be associated with positive treatment outcomes including reductions in substance use, substance use severity, substance-related problems, predatory illegal acts, and increases in posttreatment employment and earnings (De Leon, 1984b; Gerstein et al., 1994; Hubbard et al., 1989; Simpson, 1981, 1984; Walker et al., 1983; Wexler et al., 1992).

Because they work with longer term offenders, prison treatment programs can conduct substance use disorder treatment well past detoxification or even long-term withdrawal—while community programs must often address these issues while trying to rehabilitate. In prison, assessments can be more thorough, and there is time for reassessment and program adjustment to meet individual needs. The extended time frame also allows for practicing new life skills, as well as early and complete discharge planning. Basic education and mentorship programs often augment treatment in prison as well.

There are also disadvantages to prison treatment as it relates to continuity. The primary problem is "institutionalization." Learning to live in, and accommodating to, an institutional setting may make it more difficult for the client to readjust to community living. It is often difficult to maintain positive family involvement during long incarcerations. Also, while jails are located in the community, prisons are often geographically remote from the inmate's home or postrelease community.

In some jurisdictions, moving inmates from institution to institution because of limited bed capacity can be disruptive to programs. Some programs have agreements with institutions that if the risk status of an inmate in a treatment program changes (e.g., due to a disciplinary report), the offender can stay and continue treatment.

Boot Camp Programs

Boot camps, also known as shock incarceration programs, are based on a military model, and usually compared to basic military training. Boot camps are generally secure facilities characterized by a barracks-type living arrangement and significant physical exercise and discipline. One intent of military drills is for boot camp graduates to develop the self-discipline and pride to avoid future substance use. This is the theoretical underpinning of the boot camp discipline-training approach. The boot camp population generally includes

- Youth offenders
- First-time or early offenders, without a pattern of violence (i.e., offenders who have committed crimes against property or drug offenses, rather than crimes against persons)
- Probation violators (may be technical violations or new offenses)

Unfortunately, research indicates that most early boot camps fell short of their goals to reduce recidivism (Mackenzie et al., 1993). Several studies from 1990 to 1994 show that impact and recidivism were not significantly lower among prison-bound offenders sent instead to boot camps. The studies also indicate that treatment interventions and aftercare followup are important factors in actually reducing offenders' propensity to commit crime once released from boot camps (MacKenzie, 1990, 1993a, 1993b; MacKenzie and Piquero, 1994; Parent, 1993).

The extent of substance use disorder assessments and programming varies from boot camp to boot camp, but many programs have recently developed more intensive programming, including substance use disorder treatment. The Lakeview program in New York (see box) has been a model for many of these program-oriented boot camps.

In recent years, many boot camps have evolved away from punishment and military-style behavior change toward a greater emphasis on (re)habilitation. Surveys of boot camps indicate that apart from physical training, half of the program time is focused on substance use disorder treatment, education, and vocational skills (MacKenzie, 1993a).

Youth Detention Facilities

Youth detention facilities provide temporary care of juvenile offenders (or juveniles alleged to be delinquent) who require secure, physically restrictive custody pending other action in the juvenile justice system. Youth detention can take place pre- or postadjudication, and facilities are usually under local jurisdiction. Offenders are generally detained for relatively short periods of time with the goal of determining their needs and quickly moving them back into the community or into a less restrictive setting. Often, disposition of an offense will include a term of probation with a variety of conditions, including substance use disorder treatment.

Youth detention facilities differ from youth correctional facilities, which are usually under the jurisdiction of the State. Generally, correctional facilities have a higher level of security, offenders have longer sentences, and the facilities are mandated to provide education and other rehabilitative services. Although this section focuses on youth detention facilities,

Model Shock Incarceration Program: Lakeview

An example of a successful program is New York's Lakeview Shock Incarceration program, which has served as a model for many other jurisdictions. The State of New York provides a strong linkage between incarceration and aftercare for offenders having a substance use disorder. Lakeview is an example of a transitional program that reaches out to the community—it is highly structured, with a continuum of care that includes institutional and community components. The aftercare model combines intensive supervision, education and/or vocational training, job development and placement, a continuing program to maintain cognitive and behavioral changes initiated during incarceration, and continued substance use disorder prevention or treatment.

Two to three months prior to an offender's release, work begins on preparing the offender for aftercare. A parole summary is prepared and submitted to the Parole Board, which must approve the offender's release. Information about where the offender intends to live after release is also investigated and checked for suitability. Once the offender is released, he is subject to intensive supervision, which includes weekly home visits, a curfew, and weekly urinalysis testing. In addition, parolees in New York City are guaranteed jobs at a local work program and are provided with decisionmaking skills training and substance use disorder and relapse prevention counseling. After 6 months, successful offenders are downgraded to regular supervision status.

many of the same transitional issues are applicable to youth correctional facilities.

For youthful offenders, the period of community supervision is generally longer than the term of detention. This is particularly true for the very young offender. For example, a 13-year-old may spend only several months in detention but may remain under the jurisdiction of the juvenile justice system until her 18th birthday. The authority to apply sanctions to youth until they reach the age of majority is one of the factors that distinguishes the youth from the adult justice system.

There are many other differences between the adult and juvenile justice systems, including basic goals. The goals of the adult system include deterrence (both individual and general), punishment, incapacitation, and rehabilitation. The juvenile justice system generally does not emphasize punishment—although this is changing in response to public concerns about youth violence. As the juvenile offender has most of his life ahead of him, the intent of the juvenile justice system is to correct youthful behavior through rehabilitative means, even if those means are coercive. Rehabilitation efforts are often extensive. Legal sanctions and mandated participation in treatment may be imposed for those youths assessed with substance use disorder problems. The goal is to bring as much leverage as possible to the child and family in order to achieve successful outcomes.

The temporary duration of juvenile detention, the age of the clients, and the responsibility of the juvenile justice system to act in a parental capacity make the transition and treatment needs of juvenile offenders unique. Additionally, some juveniles are held as "status" offenders; that is, certain behaviors are legally forbidden only because they are juveniles, such as truancy or running away.

Model Program: Office of Juvenile Justice and Delinquency Prevention's Intensive Community-Based Aftercare Programs (IAP)

The IAP program is a model program emphasizing the value of aftercare for youth offenders (Altschuler and Armstrong, 1996). Implemented in 1995 in four sites (Colorado, Nevada, New Jersey, and Virginia), the IAPs provide

- Prerelease and preparatory planning during the confinement period
- Structured transition with institutional and aftercare staff involvement through the community re-entry period
- Long-term reintegrative activities emphasizing service delivery and social control

Some applications use recent technological advances such as electronic monitoring and enhanced drug testing. IAPs rest on the premise that the target population of delinquent and troubled youth has complex and serious needs and deficits that must be addressed early, requiring a comprehensive barrage of integrated services and collaboration among service providers.

The IAPs use a system of graduated responses (consequences and incentives) to ensure accountability (Altschuler and Armstrong, 1996). These range from work program assignments, community service orders, and timeout in detention to short-term placement in a secure unit (Denver). In Nevada, a curriculum taught during the month before release focuses on social skills training and issues related to street readiness. Additionally, an educational liaison worker is assigned from the school district most of the children will be returning to. In Norfolk, Virginia, there are monthly visits from senior parole counselors before release, and postrelease visits to the home at least three times a week (Altschuler and Armstrong, 1997). These include weekly family meetings and unannounced spot checks at school, home, or place of employment. While this program is still in the pilot stage, it includes many of the components and approaches recommended by the Consensus Panel.

Juvenile justice system goals emphasize

- A balanced approach to juvenile court interventions
- Community protection
- Accountability
- Competency development
- Individualized assessment
- Due process protection for youth involved with the court
- Manageable caseloads
- Appropriate dispositions
- Involvement of the juvenile's family
- Community-based interventions
- Victim involvement
- Meeting the needs of youth from special populations

Assessment and disposition of juvenile cases

During assessment, public safety should be a major consideration along with rehabilitation of the juvenile offender. Risk management may be handled informally: The youth could be remanded to the custody of parents with the condition that the family undergoes family counseling, or he could be placed in a foster or group home. Addressing offender needs will help ensure public safety by lowering the likelihood of crime and relapse to substance use.

Model Program: Trans House

One component of the treatment program run by the San Francisco Juvenile Probation Department is Trans House, a halfway house for youth convicted of substance-related offenses. Most of the youths in this program were involved in the sale and distribution of controlled substances; few had severe addiction problems. The focus of the residential transition program is to rechannel leadership abilities through a mentorship program that allows the clients to work with younger children and make presentations in schools. The mentors are paid $10 an hour for up to 20 hours a week, providing them with a financial incentive.

The assessed risk and needs of the individual juvenile offender should drive the case management plan. Questions to ask include, "Does the juvenile need substance use disorder treatment? Residential services? Mental health services? What educational services are necessary?" Generally, transitional programming begins at the disposition stage for youngsters in juvenile detention. Disposition may be long- or short-term, or may be an informal adjustment handled in or outside of the court system.

The role of the family in treatment

When a child or teen leaves a youth detention facility, there are a number of options for placement and treatment. In most instances, juveniles will be released to the custody of parents. However, there is sometimes a need for an out-of-home placement. Charges or suspicion of abuse, neglect, or exploitation on the part of the parent(s) or caretaker(s) must be investigated before placement.

For the youthful offender, transitional and treatment services may involve not only the behavior of the offender, but that of other individuals as well, including the parents. It is not unusual for parents or guardians of young people in juvenile detention to need ancillary services such as substance use disorder treatment, social services, or vocational

Model Program: Denver Juvenile Justice Integrated Treatment Network

The Denver Juvenile Justice Integrated Treatment Network model coordinates State and local entities to provide a comprehensive continuum of care to 500 juvenile offenders with substance use disorders and their families each year. The Network is composed of over 200 public and private systems, including every State and local juvenile justice agency, the Denver public school system, State departments (e.g., child welfare, human services, substance use disorder treatment), treatment providers, and community-based organizations. During the development stage of the network, representatives from these various organizations met to identify obstacles to effective service delivery and created strategies to overcome them. A Local Coordinating Committee oversees the network process, and the Denver Juvenile Court serves as the lead agency.

Rather than trying to develop new resources, the network expands upon and coordinates with existing programs to enhance service delivery. It has developed cross-system training for its members and an integrated management information system to improve information flow across systems. It has also centralized the assessment, treatment, and case management process for substance-using juveniles by entering into memoranda of understanding with 88 agencies. All 88 agencies have agreed to accept common instruments, refer or accept referrals for services, and participate in the network's MIS, cross-training, and outcome evaluation.

rehabilitation. A composite assessment of the whole family opens up the possibility of the need for many treatment and ancillary services.

Whether the family needs direct services or not, family involvement is critical for the success of substance use disorder treatment for a juvenile, since the family is an integral part of the transition and rehabilitative process. Effective parenting and support can provide positive influences on the substance-using youngster; conversely, if parents or other family members are themselves substance users, this can exacerbate the problems of the child. Case management for the youth is actually total family management and may include parent education and family therapy.

The recent advent of pilot family drug courts shows considerable promise in dealing with substance use disorder issues of parents and providing for support services and permanent placement of children involved in neglect and abuse cases. Such courts are now operating in Jackson County (Kansas City), Missouri; San Diego County; New York City; Reno, Nevada; and a handful of other jurisdictions.

Guidelines for Community Programs

Community treatment programs providing services to offenders in transition from institutional settings must be prepared for certain complications. Offenders have ongoing responsibilities to the supervision agency. Thus, community programs must be prepared to report offenders' progress to supervising agencies, as well as address motivational issues associated with mandated treatment. In addition, many offenders in transition lack such essentials as housing, employment, and family support. The successful community program will have realistic expectations of offenders who are entering unfamiliar territory in life following release. Community treatment providers must also examine their own preconceptions about "ex-cons" to make sure they treat offender clients fairly.

This section is for those community programs that provide substance use disorder treatment to offenders, including licensed residential treatment facilities, residential programs with a licensed treatment component, outpatient programs, intensive outpatient programs, substance use disorder awareness and education programs, and relapse prevention programs. Depending on the type of facility or program, there are variations in terms of the comprehensiveness of the assessment, extent of case management planning, levels of care, and availability of resources. In all settings, a variety of legal mandates and community supervision requirements will apply.

Identifying the Role of the Releasing Agency During Transition

Community programs should determine the degree to which the releasing institution has addressed the key components of a successful transition: assessment, case management planning, and identification of the community resources necessary to support adjustment in the community. The community program should ask:

- How does the releasing agency determine the offender's needs after release and the appropriate level of supervision?
- What kind of case management planning is conducted to respond to those needs?
- What documentation is available to describe the results of these efforts?
- Is information maintained on treatment summaries and recommendations, consent forms, and assessments of medical, family, psychosocial, and mental health status?

- Will the agency release the offender's records in a timely manner to the community supervision authority and community treatment provider?
- If the releasing agency addresses transitional planning, what are the components of the transition plan? What other agencies should participate in a transition team to plan case management and implement tasks during the transition period?
- To the extent that transition planning is not performed by the releasing agency, how can another agency or agencies address the delivery of community-based services?

The Consensus Panel makes the following recommendations regarding the goals for communication with the releasing agency:

- The community provider and the releasing agency should discuss the roles of each agency during the transition.
- Community programs should become familiar with the forms and legal requirements used by releasing agencies. They must also be aware of the restrictions placed on the offender returning to the community, and the ways in which these restrictions affect the treatment process.
- Whenever possible, community agencies and releasing agencies should collaborate in designing forms to record offender progress.

Building on the Treatment Provided in the Institution

The community provider must find out what kind of therapeutic interventions occurred in the institution and develop a plan for the community program to build on these interventions. Specifically, the community agency needs to determine whether there was

- A comprehensive substance use assessment
- A formal substance use disorder treatment program
- An educational program
- Vocational training

The range of possible approaches to treatment in the institution and the offender's response to them can vary greatly. One individual may be released from a boot camp in which he internalized a great deal of structure and is therefore very compliant. Another individual may have been incarcerated several times and may have "failed" in six or seven treatment programs. These past failures may make the offender more difficult to engage in treatment, and the community provider must be prepared for this.

If formal treatment took place, there must be a clear understanding of what it entailed and the best method for building on it. Information on the components of the program and its duration is necessary to determine appropriate followup services. For example, if a long-term treatment goal is to promote self-sufficiency, to what extent were these skills developed in the institutional setting?

There are also negative behaviors learned in institutional settings. Community agencies need to be aware of the offender's disciplinary issues, substance use within the institution, and the other, more subtle influences of institutional life that may result in offenders attempting to deceive or mislead treatment providers. Unless they ask about these issues, community agency personnel may not receive this information.

Community providers should be particularly prepared for two behaviors that offenders may learn in institutions, both of which can make treatment extremely problematic. First, offenders learn that showing tender feelings or weakness in an institution is very dangerous and places one at great risk of emotional and physical assault. Second, they often become "institutionalized"; that is, they become habituated to institutional norms and control—

from getting up in the morning until lights out at night. If an offender has been in an institution for a long time, it will be very difficult (and scary) for him to learn to take responsibility for his daily activities. These two behaviors reinforce each other in ways that can undermine treatment.

The most successful programs work on issues directly related to the factors that lead to criminality rather than on general life enhancement. Such issues are best addressed by methods that make use of reinforcement, graduated practice, modeling, and cognitive restructuring—particularly with higher risk cases (Holt, 1998).

Training Counselors To Work With Offenders

It is important for community-based treatment providers to understand the emotional and social needs of their clients. Without this understanding, the offender and the treatment provider will not have shared expectations, goals, and objectives, and offenders in transition are not likely to become or remain engaged in treatment.

Community treatment providers working with offenders should receive education about the mores of the criminal subculture, the prison environment and structure, offenders with substance use disorders, and the criminal justice system in general. The Center for Substance Abuse Treatment (CSAT) and Virginia Commonwealth University have developed *Criminal Justice-Substance Abuse Cross Training: Working Together for Change* (Virginia Addiction Technology Transfer Center, 1996), which addresses such issues. This 15-module training manual provides instruction on the ways in which treatment and corrections systems can work together effectively. This curriculum was designed to be adaptable for different audiences and is available from Virginia Commonwealth University Addiction Technology Transfer Center. Similar training programs have been developed and implemented by the New York State Office of Alcoholism and Substance Abuse Services and the Oregon Office of Alcohol and Drug Abuse Programs. The training explains the criminal justice system to counselors, and helps them recognize and respond to offender clients' cognitive distortions that support both criminality and addictions.

Model Program: Washington County, Oregon

The Parole Transition Demonstration Project of Washington County, Oregon, is designed for offenders who will be paroled to the county upon release. This project involves the following elements:

- *Provider reach-in*—Counselors from the county meet offenders months before their release and conduct group counseling.
- *Multiagency planning*—The release planning process involves institution and county staff and the offender.
- *Intensive supervision*—Parole officers have frequent contacts and monitoring.
- *Treatment continuity*—Group counseling in the community is provided by the same counselor who conducts groups in the institution.
- *Careful management of incentives*—Participants in the project receive special incentives in the community, including housing and employment. They are more closely monitored than other offenders and lose privileges and incentives as a result of rule violations.

Voluntary Versus Mandatory Treatment

Community programs must understand how substance use disorder treatment fits with the legal and supervision requirements on the offender. The provider must be sure that the client is aware of any mandatory requirements for treatment. While the offender may not agree with these requirements, he must be aware of them and understand them.

Even the client who wants to work with the treatment provider is often motivated by the desire to complete a specific supervision condition, rather than by a long-term rehabilitative goal. In an institutional setting, offenders may be motivated to enter treatment for incentives such as early parole or improving their security classification. For female offenders, one motivating factor might be the possibility of regaining custody of children. In some cases, treatment is offered as an alternative to incarceration or as a condition of release. At its best, the treatment process changes the negative attitudes and limited goals. As the client becomes engaged in the treatment process and sees the possibility of change, there is usually more investment in the process and an internalized motivation for self-improvement.

Even if the offender enters treatment merely to fulfill a condition of probation, this does not mean that treatment is of no value. In fact, studies indicate that coerced treatment is as effective as voluntary treatment, in part due to the fact that clients remain in treatment longer, and a longer length of stay is associated with reduced rates of relapse (Weinman, 1992; Young, 1995; Inciardi, 1996).

Model Program: Texas

In Texas, the Department of Criminal Justice includes the Parole Division, the Institutional Division, and the Community Justice Assistance Division (i.e., the probation authority). Because these divisions receive funding from the same source and answer to the same authority, the offender client receives consistent, ongoing care under a uniform treatment philosophy. States whose criminal justice systems are configured this way can better provide consistent funding and treatment to offenders moving through the criminal justice system.

4 Administrative Guidelines

The development and implementation of transitional programming for offenders requires an effective partnership among diverse criminal justice, substance use disorder treatment, and social services agencies. The designated transitional program administrator must be thoroughly knowledgeable of the obstacles inherent in launching such a collaborative effort. As each agency brings its own culture, agenda, and operational differences to the planning process, administrators from each of the participating agencies must work together to establish compatible goals, policies, and procedures. At the outset of the planning process, the need for individual and organizational flexibility and genuine cooperative effort should be emphasized to all participants.

The role of the administrator of a transitional services program is critical. This individual shoulders the responsibility for managing complex interactions among all agencies and institutions involved in criminal justice accountability and service provision. Therefore, the administrator must be thoroughly familiar with the environments in which participating agencies operate and lead the effort to unify policies so that communications with other organizations and with offenders served are consistent. Knowledge of each agency's administrative environment and procedures improves the likelihood of an effective collaboration.

At the beginning of the planning process, the transitional program administrator and the participating agency representatives should focus attention on several issues that, if left unaddressed, will have a serious impact on the success of offender transitions and the transition program itself. Key issues for consideration are discussed below.

Building an Effective Partnership

Selection of Appropriate Representatives From Each Agency

Ideally, each agency's representative should be a senior staff member who has authority to speak for the agency, make commitments on behalf of the agency, and sign agreements or other official documents. Final sign-off authority is extremely important. The transitional services program administrator should resist any attempts to assign staff members who do not have such authority. However, since partial authority is better than none, accepting representatives who can approve some elements of the transitional program may be necessary if that is the only alternative.

Including other stakeholders (e.g., judges, legislators, advocates) may prove beneficial to the success of the program. For example, if legislators become part of the planning process, they may become advocates for funding.

Support at this level can be essential to program implementation and long-term funding.

Knowledge of the Partners and Their Histories

Each participating agency should have a working knowledge of every other participating agency's policies, internal dynamics, service capacities, legal responsibilities, and authority in relation to the client. This knowledge is essential for the development of mutual respect among the partners. Additionally, familiarity with the organizational history of each agency, including success in collaborative or partnership efforts is important to the planning process. Agencies that have had difficulty sharing authority or yielding control may need to be treated with special sensitivity and attention.

Awareness of Obvious Conflicts in Operations, Policies, and Procedures

Each agency representative should take responsibility for determining how collaboration on transitional services may affect the internal operations of his agency. Coupled with this analysis is the need to make adjustments to ease service planning and program implementation. For example, an agency headed by a board of directors that must approve changes in operations or policy will need extra time to obtain approval.

Recognition of the Partnership as a Hybrid yet Single Entity

The nature of transitional service programs is complex in that several service providers must function as one. Therefore, the organizational goals and culture of each agency must be blended with the others. Differences will exist in professional jargon, organizational structure (including chain of command and identity of the official invested with authority for various programming issues), and the amount of time each agency will need to obtain approval. To mediate these and other differences, the transitional services program administrator can remind the participating agencies that the goals and objectives for each agency and for the partnership are the same.

Education of the Partners

An educational effort may be required to align the partner agencies in an understanding of client characteristics and the diverse agency planning, processes, and programming that may be at play. Agencies that have not worked with offenders will need training on the kinds of issues these clients bring to service providers and on the community concerns that may surface. They will also need to develop an understanding of criminal justice processes and the operating principles that govern community-based organizations and other groups in the partnership, as well as the political forces that shape each agency's agenda. For example, jails and prisons have been under enormous pressures to reduce their populations through the targeting of specific offender populations for diversion. Identification of these target populations will generally include determinations regarding substance use disorder histories. For planners of transition services, this is an important opportunity, as it provides the political motivation to move offenders from jails and prisons into community programs under a carefully designed transition process.

A delicate balance must be reached in order to reconcile differences in policy and procedures among the partnership agencies. Differences left unaddressed at the organizational level can prevent effective service delivery and undermine the program. Figure 4-1 presents a brief developmental scenario of a successful transitional services program.

Figure 4-1

An Example of Effective Partnership

An agency has received legislative authority and funding to create a transitional services program for substance-using boot camp graduates who are returning to the community. Through a series of planning and development meetings with key administrators and program officials representing four other participating agencies, agreements were reached to address

- Common goals and objectives for the transitional phase
- Agency responsibilities for offender risk and needs assessment
- Case management plan development
- The timing of components of transitional services, some of which begin while offenders are still in boot camp
- The collection and transmittal of offender-specific data relating to institutional adjustment, treatment involvement and performance, key offender demographic data, and location data (such as home phone numbers)
- Logistics issues, such as community agency access to the offender population for assessment and case management, the involvement of institutional and community agencies in care planning, what agency pays for what services, and issues related to offender release (such as custody and transportation)

These collaborative meetings were recorded by the lead agency and its clerical staff developed and circulated detailed meeting minutes. The agencies successfully negotiated all program criteria and letters of agreement were signed by all participating agencies.

Policy and Procedural Issues

Administrative Goals and Objectives

During the planning phase of a transitional service program, it is critical to agree on goals that are acceptable to each participating agency. For example, a treatment provider may see a decrease in substance use as a measure of success. The criminal justice agency, however, may believe that abstinence is the only acceptable outcome. Such issues highlight the underlying philosophies of different systems and must be identified and discussed prior to program implementation. Failure to do so may foster interagency mistrust, inmate manipulation, and dishonesty, and can result in program failure. Partnership goals and objectives must also be compatible with any legal conditions placed on an offender by the releasing or supervisory authority.

Treatment Improvement Protocols (TIPs) 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT, 1995c), and 12, *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* (CSAT, 1994c), describe basic differences in the criminal justice and substance use disorder treatment systems, and the use of sanctions in coordination with substance use disorder treatment.

Interagency Agreements

When possible, the results of negotiating the key components of a transitional services program should be documented in an interagency agreement. All policy and procedural decisions reached during planning meetings should be included in this agreement. Such decisions include

- The development of a shared "vision statement"
- Goals and objectives of transition programming
- Each agency's specific roles, expectations, and responsibilities
- Timing of tasks
- Monitoring procedures
- Shared information requirements
- Client confidentiality
- Program evaluation needs

These agreements serve as a written reminder of each agency's responsibilities, describing which agency takes the lead and which staff member is responsible for carrying out each task.

It is important to realize, however, that interagency agreements must be renegotiated at least every 2 years, and that multiagency planning requires flexibility—particularly during initial implementation—which should be viewed as a period of "testing the theories." A more thorough discussion of the process of building an interagency agreement can be found in TIP 12 (CSAT, 1994c).

Effective Communication

Because transitions involve multiple systems and agencies, policy issues inevitably arise: disagreements about treatment methods, differing philosophies, conflicts about who should take responsibility for resolving problems, and disagreements over roles. To minimize conflict, there should be intersystem and interagency agreements at all levels within the corrections system, the supervising authority, and the treatment system. These agreements should specifically describe roles, responsibilities, confidentiality issues, and policies on the transfer of records, who pays for treatment, the structure of communications, program implementation, and methods for resolving disputes.

A primary goal of such agreements is to help each partner understand the roles of both the criminal justice agencies and the treatment providers by holding these discussions early in the planning process. Policies must be developed at the highest levels, and vigorous efforts must be made to promote and ensure commitment among staff members, including administration, management, and staff.

There are times when effective interagency coordination is less a result of established policies and practices and more a result of good personal working relationships and a vision shared by a few front-line staff. In some instances, when the group membership changes, the interagency coordination may fail if new team members do not support the vision. Therefore, interagency coordination should be institutionalized and maintained by senior administrative personnel. Highly motivated front line staff members who volunteer to take these administrative positions are often invaluable in promoting and sustaining interagency coordination and partnership.

Coordinated public policy

State and local policies related to substance use and its treatment for offenders are often in a state of flux, even in the short term, with leadership from administrative agencies and the different branches of government sometimes following different—and occasionally conflicting—visions of what is in the public interest. Policies on offender rehabilitation and the impact of treatment are part of this policy debate. Ideally, the vision of offender rehabilitation and treatment should be coordinated at the highest levels of State government, starting with the governor and State legislature. Legislative support is crucial, especially with regard to funding and other critical policies. To enlist legislative support, State decisionmakers and policymakers must be apprised of research demonstrating the impact and cost-effectiveness of offender treatment and the significance of the transition period. (More detail on legislative issues is provided in a later section of this chapter.) Once sufficient agreement among key policymakers is reached, policy statements should be developed that apply to all partners.

For example, resistance to offenders' return to the community should be addressed as a matter of public policy. Upon release, offenders should be able to remain in or go to a different community to participate in treatment, even if the program is not in the county of last commitment or location of last residence. This can be especially important if the last place of residence was a high-risk area for the offender who wants to avoid these risks. Therefore, the Consensus Panel recommends that States, counties, and other jurisdictions develop policies that permit offenders who are being transferred from prison to community treatment to go into a community other than that of last commitment or last residence. A system should also be established that allows the client to move up or down on the treatment intensity scale and to be placed in the least restrictive setting required. That is, a client with a number of positive urine tests could move to a more intense level of treatment rather than automatically being removed from the program and placed back in the general population.

Other offenders, however, may want to return home but the community resists—a "not in my back yard" syndrome is especially virulent with regard to specialized housing for offenders. Many of these public fears are related to misconceptions about criminality and substance use disorders. Yet research demonstrates that providing treatment and transition services reduces the risk of criminality and substance use disorders among offenders. Providers of transition services should accordingly promote community buy-in for transition efforts. This can be accomplished through public education, public relations, and media campaigns. The general public, community decisionmakers, and politicians should be educated about the fact that most offenders are going to be returned to their home environments or communities and should receive rehabilitation services in order to be successful there.

Clarification of Roles

Unless one individual has been designated as the lead for transitional program planning and administration, the individual and organizational roles and responsibilities within each agency in the partnership must be delineated. These decisions should be made as early as possible in the planning phase. The establishment of a distinct, but interdependent role for each collaborating agency is fundamental to success. Agreement must be reached on specific issues, such as who takes the lead, who will schedule meetings, who records and distributes drafts of meeting minutes, and how meetings will be run.

Since administrative support functions of a transitional services program are critical to its success, decisions about responsibility for these functions should be made carefully. If no one person has been designated as administrator for the program, each partner should participate in determining how staffing should be handled. There may be a position in one of the agencies that can be reassigned to this effort, or tasks may be added to an existing position. In some cases, a new position must be created, which requires a funding commitment and supportive personnel policies.

In addition, because staffing will cross agency lines, agreement on cross-training is strongly recommended to increase the knowledge of all staff members and to foster a comfort level that facilitates communication.

Figure 4-2
State Level Case Management

In California, case management programs are funded through the Department of Corrections. The case managers, who are based in the prisons, keep track of the progress of the client, work with the parole officer, and follow the offender through all aspects of the treatment process.

In many States, parole and probation officers have specialized caseloads that include only offenders with substance use disorders. These officers receive specialized training in substance use disorders. It is significant that when Texas implemented its program in 1992, these specialized officers were in addition to, not in replacement of, existing officers.

Cross-training should focus on the philosophy, goals, semantics, and operations of each partnering agency. Cross-training reduces intra-agency personnel problems, distrust, and the potential for offender manipulation.

Case Management Planning

Case management planning and its implementation are at the heart of effective transitional services. Each participating agency administrator must ensure that the agreements reached among the partners address the timing, methods, and responsibility for case management. Administrators also need to be aware that case management planning for transitional service is unique and influenced by several factors:

- A team approach to case management planning is often required, since supervision and service delivery will include a variety of community agencies.
- The releasing agency and the community-based agencies must be invested in the transition process.
- Cross-training in case management planning should be conducted to ensure that all personnel follow the same planning procedures.
- Policies or agreements on risk assessment and needs assessment instruments should be made during the case management planning phase. Existing means for assessment must be reviewed to decide their applicability to the transition program (see Chapters 2 and 3 for descriptions of comprehensive assessment).
- Within the case management plan, policies on postrelease supervision of offenders must include the full range of responses to offender behavior, such as the response to relapse. Will a relapse lead to increased supervision or treatment? At what state will relapse be grounds for parole or probation status violation or revocation? The responses for other offender behaviors could include increased intensity of treatment, community service work, short-term detention, or jail.

Recommended administrative strategies for improving transitions

The National Task Force on Correctional Substance Abuse Strategies (1991) makes the following recommendations on linking corrections and community resources:

- Cumulative information—with the offender's consent—should follow the offender from the earliest impact point throughout the entire process.
- Assessment and treatment information—with the offender's consent—should be shared with all programs providing treatment services to the offender.
- Continuing care plans should be developed prior to transitions between and from correctional facilities and agencies.

- Formalized agreements should be developed among State and local agencies in the correctional system and treatment community to detail areas of responsibilities, services provided, and mechanisms for exchanging information.
- Combined case planning should be accomplished among correctional and treatment agencies when working with the same substance-using offender and when transferring the offender from one agency to another or from one part of the correctional system to another.
- Cross-training across disciplines and agencies should address a wide array of treatment techniques, case management issues, and criminal justice concerns, and should be conducted on an ongoing basis for professionals and paraprofessionals working with substance-using offenders.
- A management information system (MIS) should be established and used within and across systems to monitor the delivery of appropriate substance use disorder programming to offenders, collect data for program evaluation, and establish a rationale for additional interventions and staff.

Information Sharing

During the planning phase, types and amounts of information to be shared must be considered a central issue, and the resulting decisions should be clearly defined. The individual(s) responsible for information transfer and the timeframes to which these are bound should be specified for each partner.

During planning discussions, each agency should be prepared to contribute its lists of the types of information (such as databases) that are available for the information sharing process. Every effort should be made to avoid requesting data that are not being collected or asking some agencies to find or create information that is needed for the transitional services program only. Acceptable substitutes should be discussed. For example, if 90 percent of the data needed for the partnership's purposes exists in one agency's client discharge summary, that form may be acceptable even without the additional information. Once existing data have been identified, the partnership should discuss the need to generate "new" data that are not currently being gathered in any system. These plans should include funding for the development of adaptations to each agency's MIS.

One way to generate data for all parties is to use automated MIS, which also are valuable mechanisms for promoting interagency cooperation and increasing the likelihood of successful transfers. These systems can permit all players to have rapid access to the same information, provided the Federal confidentiality regulations limiting access to information about offenders in treatment are followed. They help promote consistent and multi-use forms that can be used by multiple agencies. An MIS can help decrease resource duplication and enhance consistency of information. Also, such systems can have important roles in conducting quality assurance checks. If possible, an automated MIS should be established and used within and across systems to monitor the delivery of appropriate substance use disorder treatment to offenders, collect data for program evaluation, and establish a rationale for additional treatment and staff (National Task Force on Correctional Substance Abuse Strategies, 1991).

Integrated information systems are beginning to be developed to facilitate the ongoing communication, data collection, and evaluation of cross-system programs. A shared data system, with data elements and security issues delivered by the partnership, is developed either using existing data systems or creating a new system that replaces existing systems. One example of this is the

Baltimore/Washington High-Intensity Drug Trafficking Area (HIDTA) Project. The Delaware drug court is beginning to design a system to draw data from the courts, Treatment Alternatives for Safe Communities (TASC), and providers into a separate system for use by all, as well as feed new data into the existing systems. This approach comes from a recognition that all involved agencies have a stake in the entire case.

Each partner may have data that cannot be shared. Strict monitoring and oversight responsibilities should be clear to ensure that the information sharing process occurs as originally specified, without compromising client confidentiality or data integrity. This topic is also addressed in the section on confidentiality below.

Information sharing plans should address the following points:

- Appropriate oversight should be provided to ensure that necessary information is being obtained. A data manager could be designated to handle information on the transitional services program.
- When existing databases will be used, their data elements, software formats, update schedules, and general availability for use should be determined. The possibility of using a shared MIS across systems should be investigated.
- Information needed for monitoring program performance and conducting evaluation should be included.
- The basic process for information sharing and the appropriate conduits for this activity (hard copy, special forms, disks, etc.) must be identified and explained.
- A method or policy should be developed to ensure that information follows a client to the next provider, especially information on treatment intensity and the extent of clients' program participation.
- Commitments should be made in writing from each agency in a letter of agreement, interagency agreement, or cooperative agreement describing specific information sharing requirements.

Procedures for Monitoring

Once representatives have agreed on the policies and procedures needed to ensure complete transitional planning and services, they must then agree on the measures by which implementation will be monitored. For example, if agencies agree that offender assessment is to be completed within 30 days of release and that case management plans are to follow within 7 working days, data showing compliance with this agreement must be maintained. Similarly, if agencies agree that positive drug tests will result in program referral and enrollment, data related to these incidents must be tracked. Participating agencies can increase cooperation with contract provisions encouraging the agencies to work together toward improved client outcomes. Mutually beneficial goals and outcomes should be set and agencies held accountable for reaching these goals and outcomes.

Legislative Issues

States have historically legislated policy for correctional programs. In recent years, program policies have increasingly been tied to costs, with delegation of authority placed where legislators see fit. Some lawmakers have advocated alternatives to incarceration for treatment purposes. Other legislatures have created situations that negatively affect the linkages between criminal justice and substance use disorder treatment systems. Legislative attempts to regulate offender substance use disorder behavior have led to the imposition of several new sanctions:

- New laws mandate subsidiary offender punishment, such as revoking convicted drug felons' rights to receive benefits from entitlement programs such as welfare.
- Additional penalties are imposed on offenders by agencies other than corrections. For example, public housing authorities may evict a substance-involved tenant who does not provide a copy of her treatment record. Or the child welfare system may be more likely to take away custody of children.
- With reforms of the welfare and health care systems (e.g., Hatch Amendment), funding for offender treatment and eligibility for public assistance and Medicaid must be monitored for individuals with felony convictions.
- Other types of sanctions against substance-using offenders have been imposed, including ineligibility for loans, professional licenses, research grants and fellowships, and federal contracts and purchase orders; denial or revocation of passports; and suspension of driver's licenses or occupational licenses (Bureau of Justice Statistics, 1992).
- The "get-tough" stand is eliminating the treatment alternative for many convicted of a violent offense, those who may have longer substance use disorder histories and greater criminal histories—those who will need treatment the most.

Legislative mandates on institutional and transitional programming can also be positive, creating the opportunity for offenders to receive treatment or promising service improvement. For example, some legislation requires the creation of separate treatment facilities or programs within the jail or prison system; other regulations require that current institutional treatment programs conduct transition planning and services.

State legislatures have a tremendous capacity to shape policies, organizational structures, resources, and programs related to the transition of offenders from institutional to community-based treatment. For example, New York's Managed Care Law sets an important precedent: Managed care organizations must pay for treatment, up to the limits of the plan, if the court orders such treatment.

Figure 4-3
State Legislatures and the Delivery of Transitional Services

The State can

- Define who is in charge of the transition process (department of corrections; each prison; parole/probation system; or other third party, including TASC)
- Pass laws that dictate eligibility criteria for prisons, jails, boot camps, and youth detention facilities (for example, structured sentencing laws)
- Determine the funding levels and requirements for funding substance use disorder treatment for offenders and specify annual appropriation needs
- Create policies dictating the process by which transitional issues are addressed (e.g., policy can mandate that State-run boot camp programs include a transitional phase designed in collaboration with community treatment agencies)
- Specify treatment resources such as residential and substance use disorder programs dedicated to offenders leaving institutional care
- Earmark funding for research to demonstrate the effectiveness of transition efforts

Transitional service program administrators should have a keen awareness of how State legislatures can affect their programs or larger policies. Changes in mandatory sentencing or drug laws can have a major impact on who comes into institutions, how long they stay, and the conditions under which they are released. In response to the continually changing legislative climate, a transitional services program administrator must educate the legislature on the necessity for these services, be aware of opportunities to help develop new legislation, and identify the need for changes in existing legislation that presents obstacles to successful offender transition. This can be accomplished in part by working with individual representatives who are interested in or have responsibility for regulating substance use, criminal justice, or health issues. Legislative briefings with all agency partners in attendance are also very effective. The administrator has the responsibility to develop programs that are compatible with current legislative mandates and requirements. Examples of legislative opportunities and obstacles are described in the following sections.

Legislative Opportunities to Support Transitional Services

The three most important legislative opportunities to enhance transitional services programs for offenders result from provisions made in (1) community corrections acts, (2) structured sentencing laws, and (3) truth in sentencing laws.

1. *Community Corrections Acts:* Increasingly, State legislatures are passing laws that create local planning boards charged with responsibility for comprehensive planning for local corrections systems. Among other objectives, these boards help develop jail-based treatment programs and aftercare. Community corrections acts generally reduce prison admissions for nonviolent offenders, who are instead sentenced to local sanctions and services and have increased opportunities for treatment, often with State subsidies. Such laws may also provide sentencing alternatives, such as "split sentences" that begin with treatment during jail time and continue with community treatment options following release. In Oklahoma, community correction boards must include not only justice representatives, but also treatment and social service agencies and community members at-large.

2. *Structured Sentencing Laws:* Such laws generally reduce judges' sentencing discretion by mandating prison sentences for some high-risk offenders and community-based sentences for low-risk offenders. Other offenders may not receive prison sentences. These laws may expand the population of offenders for whom community treatment may be expected following a period of incarceration.

3. *Truth in Sentencing Laws:* These laws provide an opportunity to mandate treatment as a sentence for offenders who commit low-level crimes. Mandated treatment may assist in reserving prison space and allocating more funds for the institutional treatment of serious offenders. In the case of more serious offenders, these laws sometimes mandate that the actual time served in institutions closely approximate the amount of time ordered by a judge. Truth in sentencing laws may compel certain offenders to spend long terms in prison.

Legislative Obstacles to Effective Transitional Services

State legislatures have the authority to determine many issues critical to the successful transition of offenders from institutional to community treatment settings. Legislatures determine which agency is in charge of parole, probation, and community treatment. The legislature may also determine the agency in charge of transition to the community and/or community-based substance use disorder treatment. A transitional services program administrator must be aware of the States' legislative position on these issues and the current structure of these services to effectively navigate the planning and implementation processes. If there are obstacles, the administrator must be able to identify and work with those obstacles. The kinds of legislative obstacles a transitional services program administrator might expect to encounter are described below.

- *Determinant Sentencing Laws:* These laws establish absolute terms of offender confinement and abolish early release through parole. Instead of parole, these laws may mandate a term of community supervision. From an administrative perspective, there is a custodial concern that the removal of the motivation provided by early release may lessen offender involvement in institutional treatment and rehabilitative programming. In such situations, there is a stronger need for transitional services following release.
- *Presumptive and Mandatory Minimum Sentencing Laws:* Such laws reduce or eliminate judicial sentencing discretion, particularly for substance-related crimes, and compel judges to incarcerate offenders. Transitional services program administrators must be cognizant of the increased incidence of prison admission for certain substance-using offenders and realize that once they are released, this subpopulation will need a higher level of transitional services than other groups of offenders.
- *Legislative Treatment Mandates*: State legislators may unwittingly hinder treatment services by mandating the level of treatment and/or creating specific treatment termination criteria (i.e., three dirty urine tests result in termination from treatment). Under such circumstances, treatment is not driven by individual offender needs or treatment progress. Legislators should be educated that regulations of this type negate the effectiveness of treatment and thereby increase the burden of transitional services programs. Supplying cost/benefit information to legislators may help convince them of the overall savings in tax dollars gained from reduced recidivism through effective treatment.

These and other legislative obstacles require the transitional services program administrator (and each partner's administrator) to take responsibility for shaping legislation by providing information on transitional service needs to legislators whenever possible.

Funding Transitional Programs

Agencies involved in planning for transitional programming face the challenge of finding the resources needed to complete the planning process and support ongoing operations, monitoring, and evaluation of the programming once it is implemented. Several specific areas of need were identified by the Consensus Panel and are discussed in the following sections.

Planning Activities

Planning is an intensive and time-consuming activity. If staff members involved in planning are unable to focus on their planning because of other job responsibilities, or lack the expertise to organize, create, and plan transitional programming, it may become necessary to identify new resources to support the planning process.

New funding or resources may be available from Federal, State, or local agencies, or from foundations, which often fund new services or programs. Support for planning activities can also come from reallocation of resources within participating agencies. Reassignment of staff members may facilitate some planning or program development activities.

Operational Activities

Support for ongoing transitional program operations may be generated from reallocation of existing resources within collaborating agencies or the reassignment of personnel. To create the necessary array of supports and services, programs can attempt to combine existing but separate funding streams from welfare, housing, primary medical, substance use disorder, mental health, and justice budgets. Reallocation of funds from these sources may be justified because front-end investment in transitional programming can ultimately produce long-term savings for most of these agencies.

Often, however, transitional services program administrators must identify additional sources of funding for ongoing operations or assist partnership members in doing so. Within the partnership, agencies can work together to seek additional funding from Federal, State, or local government authority. Partnerships of several agencies can leverage State money with Federal or local funding. It is critical that those agencies work collaboratively, rather than competitively, to generate funding in order not to undermine the entire process. Foundations may be willing to support model transitional programming for a demonstration period. Finally, agencies may need to find other, more creative sources of funding; some jurisdictions have tapped into resources recovered from confiscation and forfeiture of offender assets. Consideration should be given to accessing different funding streams for different groups of offenders. For example, offenders in transitional services programs for a certain period of time may become eligible for government benefits, including public assistance.

Evaluation Activities

Existing evaluation resources, brought to the table by each participating agency, can be combined for more efficient use (see the section on evaluation later in this chapter). A partnership can approach Federal, State, and local funding agencies to support evaluation research essential in documenting the effectiveness of transitional programming. Foundations may be interested in supporting the effort to document the efficacy of model programs that can be replicated in other jurisdictions.

Managed Care

Currently, the typical resources for funding transitional service programs are State budgets. Increasingly, however, treatment services and, as a result, transitional services, are funded through managed care organizations and discretionary funding. The obstacles these funding sources pose for transitional services are discussed in Chapter 1 of this TIP. It is essential for administrators to understand how funding streams and managed care initiatives operate within their community and to be involved in planning and contract negotiations of such funds.

Funding Following the Client

Funding identified for offenders having substance use disorders should be driven by client needs and should "follow the client" rather than be preallocated to specific systems or agencies. As population needs change, funding changes should follow. For example, the agency most available to provide transition services should receive the funding. When institutional treatment is available but community-based treatment is not funded, continuity of care cannot occur. Treatment providers often struggle with funding issues in relation to offenders who are mandated to treatment by the courts when there is no funding to support it.

Confidentiality Issues

Confidentiality issues affect the structure and operations of transitional services programs offered by a collaboration or partnership. As always, the central issue is balancing protection of client confidentiality and the offender's right to privacy against the needs of various agencies for information. It is critical to this goal that all partners understand the limitations on sharing of information by substance use disorder providers and the importance of safeguarding any information received from a treatment provider about a client from further disclosure to or sharing with others.

It should be noted that several other TIPs have presented information on a variety of confidentiality issues; some have done so at great length. Therefore, this TIP does not offer comprehensive information on the topic. Instead, this section describes the types of confidentiality issues that must be addressed by a transitional services program administrator and the agencies involved in a transitional program partnership. For more information on many aspects of confidentiality, the Consensus Panel refers the reader to the TIPs listed in Figure 4-4.

Additionally, the CSAT Technical Assistance Publication (TAP) 18, *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* (CSAT, 1996a), contains valuable information for determining whether confidentiality has been violated after the fact.

Confidentiality Issues for Transitional Services Partnerships

The confidentiality issue of greatest concern to a transitional services partnership is the security of client data within and across all agencies. During the planning process for information sharing, this issue should be addressed in great depth. A full discussion of electronic data confidentiality can be found in TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT, 1996b).

Other issues that should be brought to light when developing confidentiality procedures for a partnership-based transitional services program are

- The use of consent forms, including revocable, nonrevocable, limited, and other types of forms (see TIP 23 [CSAT, 1996b])
- How to handle information that is not protected by confidentiality, as this differs by program type or setting
- Appropriate confidentiality specifications for conducting program evaluation
- Procedures and rules for sharing information between service providers in the partnership
- Methods for handling disclosure of criminal acts (e.g., the variations that exist in different jurisdictions)

Confidentiality Guidelines for Administrators of Transitional Services Programs

For the administrator charged with managing a transitional services program, it is essential both to understand confidentiality regulations and to create methods by which clients are informed of their rights. There should be clear agreements concerning confidentiality within the various components of the criminal justice system and with each of the partnerships' service providers. All staff members involved with transitional services need training on the parameters of client confidentiality. To ease the development of the procedures and forms associated with maintaining confidentiality, the transitional services program administrator needs to

- Be aware of the differences between terms of consent for offenders who are mandated to treatment by the criminal justice system and those who enter treatment voluntarily

- Have a clear understanding of information redisclosure issues, the need for separate consent for followup, the right to revoke consent, and the expiration of consent
- Recognize the need to comply with other programs' consent requirements
- Have a clear understanding of differences in consent for clinicians, administrators, clerical staff, and other types of service providers
- Develop a checklist of consent and confidentiality issues (i.e., clarification of what, when, how, to whom information can be given) to review with the partnership members
- Assign a designated confidentiality expert to the task of preparing materials and procedures
- Understand the implications of confidentiality as it pertains to case management, including issues of consent that affect the disclosure of information from several agencies, the extent to which disclosure is legal and ethical, the issue of disclosure without consent, and differentiating between case management and qualified service agreements
- Understand the implications of confidentiality as it pertains to interagency, cooperative, and other agreements

When developing transitional services programs, it is also critical to maintain client confidentiality at all levels of planning and implementation.

Figure 4-4
Information on Confidentiality in Other TIPs

Confidentiality Topic	TIP #	TIP Title	Pages
General Consent	12	*Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*	71-78
Minors	8	*Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*	83-84
Communication With Others	12	*Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*	78-79
Programs in Correctional Settings	17	*Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*	81-83
Offenders Changing Treatment Programs	12	*Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*	79-80
Patients and Criminal Activity	23	*Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing*	52-55
Research	14	*Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*	58-66
Other Exceptions	12	*Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*	82-66

Program Evaluation for Transitional Services Programs

Evaluation of transitional services programs is much like that of other programs. There are, however, some unique evaluation issues, because services are provided by different agencies, and each has its interests and concerns to protect. It is essential that the planning process address evaluation issues, including what data will be used; who will be responsible for collecting data; who will assist in data interpretation; and what, how, and to whom data will be reported. In addition, a program evaluator must be identified during the early part of the planning phase. This section provides a basic overview of the evaluation of transitional services. Additionally, the Consensus Panel recommends the in-depth discussion of evaluation and monitoring found in TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drugs Abuse Treatment* (CSAT, 1995a).

Evaluation can be conducted by the participating agencies as a collective effort or by a designated third party. When transitional services in a jurisdiction are provided by many agencies, the Consensus Panel recommends the use of a third-party program evaluator. This person should clearly understand each participating agency and have access to the information necessary to conduct an evaluation.

Participation of the evaluator from the inception of the program lays the foundation for the evaluation effort, because the data elements and issues affecting program evaluation will then be identified and included. The cooperation of all partnership administrators and agency staff involved in the evaluation must also be obtained early in the process because successful program evaluation depends not only on good design and an adequate number of subjects, but also on the cooperation of staff and others involved in the intervention. This cooperation can be expected in a research environment, but in settings such as prisons, jails, probation departments, and community treatment programs, the evaluation can place demands which staff may be reluctant to assume. It is imperative, therefore, that an evaluator gain and maintain the cooperation of program staff. This can be facilitated by explaining the purpose of the study, sharing data collection instruments with staff, listening to concerns about the study, giving the staff feedback, and making them aware of time constraints.

Figure 4-5
Process Evaluation Questions

Questions to be asked when conducting a process evaluation include

- What services have been provided and by which agency?
- How often were services provided?
- Who received services?
- Was the program implemented as designed?
- What are the program's strengths and weaknesses?
- Was the program changed, and if so, how and why?
- What were the catalysts for the changes made?
- How much did the program cost?
- What were the barriers to implementation?

Purposes and Uses of Evaluation Information

There are many uses for the information gathered from a program evaluation. Evaluation not only documents program implementation but helps to guide it. Process and outcome evaluations are also used to improve implementation of subsequent programs by identifying strengths and weaknesses. Evaluation provides data to

- Justify program costs and identify cost offsets
- Establish program effectiveness or success
- Make program adjustments
- Assist in legislative decisionmaking and fund allocation
- Serve as a basis for obtaining additional funding
- Serve as a justification for expanding services

Process Evaluation

Process evaluation examines the implementation procedures and operations of a transitional services program as it compares with the program's stated goals and objectives. Process evaluation can be used to determine whether the people studied actually received program services and measures the intensity and duration of services provided. Unless evaluation describes what happens during a program, its strengths will not be known, and necessary changes in program design will not be identified. A good process evaluation suggests ways in which a program can be improved and serves as a management tool for further program development.

Many treatment efforts have been ineffectual, misunderstood, or misinterpreted because the program was not implemented as it was described in the original design. Process evaluation can be used to assess whether the program that was originally designed is the program that is being tested. A process evaluation can also help interpret the results of an outcome evaluation by providing a description and assessment of the services provided and the population receiving them.

Because several agencies are part of the service delivery continuum, process evaluation of transitional service programs requires a great deal of effort. To conduct a comprehensive process evaluation, the participating agencies must each undertake comparable process assessments, which means they must be willing and able to assess the implementation of their service components.

Figure 4-6
Data Sources for Process Evaluation

- Observation
- Agency budgets and billing information
- Client attendance records
- Staff time sheets and duty records
- Daily schedules and activities
- Staff surveys and interviews

Outcome Evaluation

Outcome evaluation determines the effectiveness of a program when comparing the group receiving services to a control group receiving no treatment, an alternative program, or standard treatment. Outcome evaluation measures a program's ability to produce expected changes in the clients who are part of the program.

Types of Evaluation Designs

- *Posttest:* In a posttest-only design, data are collected from patients at some point following treatment and then analyzed to determine if certain groups of patients have had better outcomes than other groups that did not receive the same services.
- *Pre/Post Intervention:* This design balances scientific rigor with practicality in that it allows for a measure of change over a period of time. "Pretest" and "posttest" are

analogous to "before" and "after" or "baseline" and "outcome." However, this design is limited because it does not prove a causal relationship between patient outcomes and treatment.

- *Quasi-experimental* (comparison group): In this design, patients are randomly assigned to two or more groups. One group receives the conventional treatment, while the other receives the experimental treatment or no treatment at all. This is the strongest type of research design because of its capacity for demonstrating causal relationships between interventions and outcomes.

Of the three types of evaluation designs, the use of a quasi-experimental approach is preferred. Care must be taken to ensure that the comparison group selected is truly comparable to the client population by client profile, risks, and needs, and that data on these characteristics are available. The Consensus Panel suggests the use of a pre/post intervention design if a quasi-experimental design is not possible.

As mentioned, evaluation of transitional services poses unique challenges. First, data from several agencies must be collected. Second, attributing client outcomes to a specific agency is difficult. Third, each agency may focus on a slightly different or very different measure of client success. A consensus on measures of successful outcomes must be reached in consultation with the program evaluator prior to initiation of services. The focus of outcomes measurement should be on behavioral changes, such as reduced substance use or abstinence, stopped or reduced criminal activity, compliance with supervision requirements, and stability within the community.

Evaluation Reporting

The individual selected as the program evaluator will be responsible for coordinating the evaluation effort with each participating agency. Therefore, each agency should designate a staff member to help the evaluator compile that agency's information for the report. As evaluation activities are being planned, agreement should be reached among participating agencies concerning the frequency of evaluation reporting, the data elements required for the report, and those who will receive reports. The format, length, and breadth of detail reported should also be determined.

Figure 4-7

Outcome Evaluation Questions

Examples of the kinds of questions to be asked when conducting an outcome evaluation are

- Do the transitional services reduce relapse and recidivism among offenders?
- What are the relapse and recidivism rates of offenders?
- Do the transitional services assist offenders in successfully reintegrating into the community?
- Do the transitional services help offenders improve their housing, financial, and employment status?
- Do the transitional services assist offenders in accessing other necessary services, such as primary medical and mental health services?
- Are there differences in offender outcome by participation in different services/program components?
- Which program components are associated with positive outcomes?
- Based on client profiles, which clients received the most benefit from transitional services?

Figure 4-8

Data Sources for Outcome Evaluation

- **Discharge summaries and status reports (from treatment programs, the criminal justice** supervisor[s], and other service providers)
- Drug test results
- Arrest and incarceration records
- Face-to-face followup interviews or client self-reports
- Program intake and attendance records
- Probation and parole records

The program evaluator should ensure that the final report addresses any concerns raised by participating agencies and is written in clear and concise language. Ideally, evaluation data should be collected at 3 months, at 1 year, and later, if possible. Since offender clients are often on extended probation or parole, they may be easier to track than traditional clients.

5 Ancillary Services

Offenders with substance use disorders need certain basic services as they enter the community. These services are provided by a number of public systems that are generally not well coordinated, and because of the factors discussed throughout this TIP, offenders' abilities to access these services are limited. However, efforts at treatment are unlikely to succeed unless these basic needs are met. Foremost among these needs are

- Housing
- Employment
- Family support
- Peer support
- Transportation
- Education
- Primary health care

Many offenders lack more than one item on this list, and services must be prioritized for each individual. Safe housing is the paramount need for most inmates leaving custody, yet other needs can be almost as pressing for some. For example, transportation to secure housing may be needed, or planning for medication delivery might be crucial to avoid a health or psychological crisis.

Continued recovery requires that substance use disorder treatment remain a high priority during the transition period, but treatment will almost certainly be undermined in importance if any of the supportive components is lacking. Furthermore, public safety is at risk when offenders do not receive necessary supports because they are at greater risk of relapse and a return to criminal activity.

The complexity of accessing services creates many barriers for the offender. The offender must be vested with primary responsibility for meeting her needs, but the stresses of finding housing, employment, and perhaps child care, in addition to requirements for supervision and treatment, increase the potential for relapse. Treatment schedules may conflict with parole mandates, and job-seeking or work may compete for the time allocated for therapeutic needs. Coordination of these supports based on an individualized transition plan helps keep the client from being overwhelmed.

To ensure that each offender has basic needs met when returning to the community, an effective prerelease assessment is essential. The results of the assessment shape the transition plan, and the transition team has the responsibility to integrate service delivery as much as possible.

The difficulty of coordinating services is not the only roadblock to a successful transition. Some service providers do not consider released offenders their responsibility, particularly if they cannot be easily reimbursed for treatment. Once the offender is no longer within the custody of the criminal justice system, services previously available through that system may be unavailable. This adds to the challenge for case managers or others responsible for brokering care. Returning offenders must often contend with reluctantly given support and a lack of funding for health care and substance use disorder treatment services that were previously received in the correctional institution.

Certainly the offender retains primary responsibility for his own coordination of services, yet the overlap among services and service providers can be confusing and overwhelming. If no entity is required to provide assistance, service providers may "pass the buck," leaving the responsibility for the offender to some other system. Without integration of services, the offender has no access to other systems and is left without resources. This chapter presents the critical elements of a variety of social supports and suggests methods for obtaining services within each system. Relevant examples from model programs or approaches are highlighted throughout.

Housing

It is very difficult for a substance-using offender to make a successful transition to the community without housing that is safe, secure, and free of substances. Upon release, many offenders return to the environments that originally contributed to their drug problems and other criminal activities. Therefore, making sure the offender has suitable housing should be one of the transition team's top priorities.

Model Program: The Center on Addiction and Substance Abuse Demonstration Program

CASA supports a national demonstration program that provides intensive services to offenders who have received significant substance use disorder treatment in an institutional setting and are returning to the community on probation or parole. The goal of the program is to sustain treatment gains and facilitate a "positive reintegration into the community by providing a package of aftercare services." The components of the package can include aftercare treatment, training and employment, substance-free housing, primary and mental health care, and parenting/family skills training.

A central tenet of the program is effective case management. An individualized service plan is developed in conjunction with a case manager, and a case management team, housed within the Department of Corrections, is responsible for oversight of the plan. The case manager is the primary point of contact for the offender across all systems involved in the transition plan, including the probation/parole office, the employer, and any contracted third parties. As the individual with the most comprehensive perspective on the offender's needs, the case manager monitors progress and initiates sanctions for noncompliance, alternative referrals if the initial placement is inappropriate, or may recommend re-incarceration for continued infractions.

CASA has been evaluating the effectiveness of the program for 3 years through documentation and impact analysis. The outcomes under examination include degree of substance use, involvement in criminal activity and re-arrest, employment status, stability within the community and family, and improvement in general health. Findings will be broadly disseminated for possible replication in other jurisdictions.

Adapted with permission from *Opportunity to Succeed: Post-Incarceration Services for Substance Abusing Offenders Report* published by Columbia University, New York; the Florida Department of Corrections; the Hillsborough County Sheriff's Office, Tampa, Florida; and the Drug Abuse Comprehensive Coordinating Office, Inc., Tampa, Florida.

Model Program: Oxford House

Oxford House, Inc., is a group of self-run and supported substance use disorder recovery houses. The underlying principles of the Oxford House program are similar to Alcoholics Anonymous and Narcotics Anonymous groups. A supportive peer structure provides a substitute for substance dependency on an ongoing basis. A new value system replaces the old and new relationships take the place of problematic friendships and lifestyles. Self-esteem is enhanced, and sobriety becomes habitual and easier over time.

Each Oxford House is home to a group in recovery that rents the premises to start a democratically run home and become affiliated with the parent organization. The Oxford House network limits affiliation to single-sex group houses with at least six residents. When a group has been assembled, it can formally apply for an Oxford House charter. The organization can help new groups start houses by offering financial help and guidance through the State Recovery House Revolving Loan Program and by providing technical assistance. In areas where houses already operate, interested individuals may try to join an existing house.

For both therapeutic and practical purposes, leadership of each house is elected by group members for terms that do not exceed 6 months. The democratic model emphasizes both individual and collective responsibility, an asset to recovery. Weekly business meetings are conducted that are important not only for dealing with financial matters, but to ensure that members are communicating well with each other. If some residents are facing challenges to sobriety, the meetings can provide support. If the relapse of a resident is suspected, a house vote will be taken after consideration of the facts. A finding of relapse leads to immediate expulsion. Usually, an exresident cannot return to the house, but after 30 days of sobriety it is possible to apply for residence in other Oxford Houses in the area.

Ideally, substance use disorder treatment is integrated into the housing situation in residential treatment or a halfway house.

Because safe, secure, and drug-free housing is so important—and often difficult to obtain—a housing plan should be in place before release from incarceration. The offender, along with the transition team responsible for this service, should identify a living arrangement that meets his needs and then arrange a linkage with the entity providing housing. Local housing agencies can be brought into the team as partners in this effort. Working with publicly subsidized housing, such as Section 8 housing available through the Department of Housing and Urban Development (HUD), can be time-consuming and confusing.

Graduated levels of structured living environments are helpful in easing an offender toward independent living. Community treatment providers can operate supportive living arrangements for offenders engaged in outpatient care. These would be low-cost, substance-free housing environments with a level of peer supervision and support for recovery. Some options are residential treatment facilities, transition treatment centers (such as the Key-Crest program), halfway houses, parole restitution centers, sheltered living situations (such as Oxford House; see box above), and the offender's own home. Special populations, such as mentally impaired or juvenile offenders, may have available housing designed specifically for them.

Employment

Preparing an offender to seek and maintain employment is another key element of a transition plan. Employment serves several

Model Program: The South Forty Corporation

The South Forty Corporation in New York is a nonprofit criminal justice organization that helps inmates and exoffenders make the transition to employment in the community. In several New York State correctional facilities, South Forty offers prerelease service programs that include job counseling and job readiness preparation, as well as education and general counseling. South Forty also provides postrelease services during business hours at its central office. These services include job development and job placement, vocational counseling, and educational testing. Before individuals can receive employment placement, they must participate in a 4-day orientation and workshop. The 4 days are structured as follows:

- Day 1 — Clients are introduced to the South Forty staff and informed of program requirements. Intake applications are completed, and eligibility status with Department of Employment regulations is verified.
- Day 2 — The Test of Adult Basic Education (TABE) is administered, in accordance with Federal regulations. Job Developers use the results to determine the appropriate type of work for each client.
- Day 3 — Both classroom instruction and role playing are used to help prepare clients for job interviews.
- Day 4 — Clients are helped to prepare their resumes, assessments are finalized, and job interviews for the next week are scheduled.

Over the next 2 weeks, clients are supervised and counseled during their job search. If additional interviews are required, they are scheduled. When work is secured, job developers draw up contracts with employers. There is no recruitment fee, and businesses can receive Federal tax credits for hiring offenders.

significant purposes for the offender, in addition to providing a source of income. Working augments self-esteem, provides the opportunity for socialization, demonstrates accountability for self, and is an essential step toward entering mainstream society.

There exist considerable obstacles to employment for substance-using offenders. Many lack job skills because they were unemployed or underemployed before incarceration. Offenders may also lack the social skills necessary to seek and hold jobs. Training programs conducted in prisons or jails can help offenders develop these skills and give them reasonable expectations of the types of jobs they may be considered for. It is also important that offenders develop coping skills that can assist them when they encounter negative attitudes in the community, such as the stigma associated with having been incarcerated. Disclosure of the need for substance use disorder treatment may also alienate some employers.

Planning for employment should begin well before release. While still incarcerated, offenders can benefit from job training and job readiness preparation, skills identification and assessment, role playing for future interviews and job situations, and reach-in programs that serve as quasi-internships or offer transferable pre-employment experience. Prior to release, case managers often develop a resource directory of employers that will hire offenders and talk with probation and parole officers about employment possibilities. There are often many available partners in the community ready to help with the employment component of transition.

Some correctional agencies conduct job fairs in which local businesses provide information on available positions in the community. Staff and volunteers conduct these job fairs for inmates who are about to be released. These events provide an opportunity for employers to visit the prison units and conduct practice interviews, assist with resume writing, and conduct job skills assessments. This has proven to be a "win-win" situation for employers and offenders. The offenders are prepared to seek jobs that may be available in the community and the employers fill their vacancies and network with other employers.

State and local entities have a large role in fostering job creation and placement. In Texas, Project RIO (Re-Integrating Offenders) is geared toward helping inmates make the transition back into the community. The Texas Department of Criminal Justice and the Texas Workforce Commission collaborate to provide job skills training and job referral/placement services to offenders prior to release. Often, Project RIO works with offenders to build on vocational skills to obtain employment after release. The Project maintains relationships with various job training programs and employers who are willing to hire offenders.

When an offender is offered a job, the case manager and/or community supervision officer should determine whether the job provides a supportive environment for recovery. If substances are available on the premises, the placement is obviously inappropriate. The new employer may be enlisted as a member of the community supervision team, serving as a point of support and accountability. Some employers will help a case manager monitor an offender for signs of relapse. Case managers and community supervision officers can help to coordinate the timing of service appointments so that there is no conflict with the demands of job programs and employers. It is critical that the offender satisfy both job requirements and treatment needs. For more information on employment issues, refer to the forthcoming TIP, *Integrating Vocational Services With Substance Use Disorder Services* (CSAT, in press).

Family

Families and significant others can have both positive and negative roles in offenders' lives. Some provide support for a successful transition to the community, while others may present barriers to recovery because of their own substance use (or other problems). Prior to release, it is important to know whether the offender's family environment will be a source of strength or an inducement to return to substance use and crime. Therefore, a prerelease assessment of the family environment should be conducted. This assessment should measure

- Whether other family members are using substances
- Whether there is domestic violence
- The level of support for sobriety
- Hopes regarding family reunification
- Current child care and child custody status
- The availability of family members in nurturing roles
- The family services already in place
- Areas of potential vulnerability

Sometimes it is difficult to enlist family members because they are unable or unwilling to participate in rehabilitation efforts. If the correctional facility is far from the inmate's home, it may be hard for family members to have regular contact. Paroled prisoners may not be able to cross State lines to see loved ones. In some cases, families "disown" an offender because of her criminal and substance-using behavior.

Model Program: Children's Center Summer Program

At the Bedford Hills Correctional Facility in New York, the Children's Center Summer Program gives inmates an opportunity to enjoy positive time with their children, maintaining and improving family ties. Volunteer families are recruited to host inmates' children for a period of no more than 1 week. The children spend days with their mothers at the prison in organized recreational activities. Community members give substantial support, whether as host families, providing day care, or helping with tasks as varied as making phone calls or providing transportation.

If, however, the offender's family wants to aid in the transition, the case manager should include it in prerelease sessions. Families then become an active part of the therapeutic process. Family members can benefit from support groups, such as Alanon, Narcanon, and Prison Families Anonymous, which provide peer support. Some jail and prison treatment programs provide groups for family members to help them identify relapse issues and to develop strategies to assist in the transition process.

Fostering communication among family members and probation officials and treatment personnel is beneficial as long as it does not violate confidentiality. The offender's family can receive ongoing information about ways to support, rather than undermine, sobriety and crime-free behavior. They can also be educated to become wise consumers and help in obtaining the best services for their family member. The family can also help enhance accountability, but enlisting relatives' help must be handled delicately. If a loving family member monitors for relapse and is willing to report the offender to authorities, the offender may feel he has nobody he can trust. In extreme cases, the family member might be in physical danger if the offender reacts with anger at being reported.

For women, family issues may be especially complex (see Chapter 6). As a result of incarceration, many women have had a change in family structure or relationship status. They may have been abandoned by men; if they have children, the children may have been placed in foster care or have bonded with another adult. The stress for the woman attempting to re-enter the family unit can be substantial.

The case manager can ensure that offenders with children have adequate parenting skills and access to appropriate programs. If there has been a change in custody during incarceration, the case manager may work with personnel in departments of child protective services to determine the best interests of all family members. Churches and private groups can be useful for general parenting support, and Parents Anonymous provides support for families in which there has been a history of neglect or abuse. When there is a child support obligation, the case manager can help find a means for facilitating prompt and full payment.

Peers

Peers can either inhibit or support the reintegration of an offender to the community. Many offenders have friends from their pre-incarceration days who are substance users and therefore represent a major threat to their sobriety. Because freedom from incarceration presents so many changes, offenders will naturally be drawn to the familiar, including old friends. It may be necessary to create an entirely new network of friends and to pursue new, substance-free, recreational pursuits. It is ideal to start contacts with mentors, role models, or sponsors prior to release. (Chapter 2 describes the roles of such individuals in the transition of the offender.)

Some States have laws that prohibit exoffenders and/or felons from associating with one another. These laws can have a negative effect on recovery by inhibiting supportive peer relationships after release.

Permanent sobriety often involves avoidance of people, places, and things that may trigger relapse. The case manager (or those providing case management functions) can guide an offender toward new contacts. Formal peer support groups are invaluable. A directory of peer groups and services can be maintained by the case manager, who should also identify whether support groups are open or closed to observers, their focus, and where they are located.

It is important to help inmates anticipate likely triggers for substance use on the outside so that they can avoid them. The "Opportunities to Succeed" program in Tampa, Florida, funded by the Center on Addiction and Substance Abuse (CASA) at Columbia University, is an example of an aftercare group providing treatment following release from jail. Jail alumni meet in weekly groups for 2 hours to review relapse prevention strategies. A case manager leads these groups, and family members are encouraged to participate. A similar program is WomenCare, Inc., a private not-for-profit mentoring program in New York City that recruits and trains volunteer mentors to help women released from prison adjust to life outside.

Transportation

To successfully reintegrate into the community, an offender must be able to get to work, to treatment meetings, and to appointments with parole officers, case managers, community service coordinators, and others. The case manager must ask an offender about transportation, because it may be a significant issue. For example, many offenders do not have a driver's license.

Although a lack of transportation may sometimes be used as an inappropriate excuse for noncompliance with treatment obligations, this is often a legitimate barrier, especially in rural areas. The case manager should

Model Program: The Fortune Society

The Fortune Society in New York educates the public about criminal justice issues and the causes of crime. The organization also helps exoffenders and young people avoid repeated criminality and incarceration. Because its counselors and many of its staff members are exoffenders and/or in recovery, the Fortune Society offers a powerful opportunity for offenders to interact with positive role models; it also provides a variety of transition services, including

- A Career Development Unit offering job search workshops, individual counseling, and job and vocational training referrals
- Job retention services to develop necessary employment skills and attitudes
- Sobriety assistance through outpatient drug treatment and relapse prevention programs focusing on behavioral change
- Educational assistance, including assessments, one-on-one tutoring in both fundamentals and GED preparation, and training in skills such as typing and software use
- HIV/AIDS awareness, education, and support programs
- Court advocacy and information about alternatives to incarceration
- Reach-in and outreach to both prisoners and their families to share knowledge and experience and encourage offenders to use the services of the Fortune Society

coordinate any options available and advocate for policies ensuring that offenders are transported from correctional settings to community-based programs. If the offender is being released into residential treatment or a secure facility in the community, he will need transportation from the institution.

The transportation needs in rural and urban communities are very different. In remote areas, the case manager should be aware of programs that use satellite locations in churches and other public buildings. This may affect the decision about the location of nonresidential treatment. Transportation requirements can be met by innovative means: Reconditioned bicycles have been used in one area. Vans or car pools are another option. In more densely populated areas with mass transit, some programs have provided bus tokens.

Transportation problems are not limited to the postrelease period. As part of prerelease planning, reach-in efforts by family and peers may need coordination by the case manager if the institution is far from the offender's home. A program in New York provides transportation to visitors in 50 prisons in the State for a nominal fee. Since 1972, Operation Prison Gap has transported almost 2 million individuals to correctional facilities throughout the State. It was founded by a former inmate who was concerned about family members who had no means to visit their incarcerated loved ones. Originally a small volunteer organization, it grew into a successful privately owned business that meets a vital need for offenders and their families. Some States have implemented similar programs to address this need.

Education

Education is a building block for self-esteem and employability and is therefore of great importance in aiding sobriety. Research has shown that treatment outcomes improve when combined with education programs. However, low educational attainment is common among offender populations and even those who have a diploma may have poor reading and math skills. Offenders often exaggerate or distort their background and abilities, so achievement and literacy testing should be conducted inside the institution prior to release. Some offenders try to hide their lack of literacy or claim to have graduated from high school when they have not. Others have graduated from impoverished school systems and cannot read or do arithmetic. Offenders have higher rates of attention deficit disorder and other learning disabilities than the general population. One-fourth of children with conduct disorders and attention deficit/hyperactivity disorder (AD/HD) develop substance use disorders and become involved in crime (Harvard Medical School Health Publications, 1995). Many of these children grow up "self-medicating" their cognitive problems with substances, sometimes exacerbating their mental and physical health problems. A proper assessment can help identify and remedy educational deficits and uncover special needs, such as dyslexia, AD/HD, or other learning problems. Incarceration is an optimal time for these educational opportunities.

Offenders can be helped to develop not only basic skills but also a realistic plan for furthering their education. They can be provided with continuing education opportunities and financial aid information. If an offender is ready for college, grant and scholarship information is important. Some jurisdictions charge a fee to give the GED; a case manager can help the client resolve this and other barriers to continued education efforts (such as poor time management). After release, the offender must avoid creating time conflicts among her various obligations, such as job training or securing employment, treatment, and other services. In some cases, education is mandatory, as some judges require offenders to take GED classes before community supervision ends.

A number of individuals and entities may have roles in educating offenders. The Board of Education in the locality for each prison or jail has responsibility for providing education leading to a high school equivalency degree. Literacy volunteers, mentors from the community or tutors (who may be other inmates) can also be helpful. Many colleges and technical schools hold programs in correctional facilities.

Primary Health Care

The substance-using offender population suffers more health problems than the general public. The sobriety achieved in an incarcerated setting may reveal medical conditions that were formerly masked, so that incarceration results in diagnosis and treatment. Some commonly found health problems are

- Communicable disease, including HIV, STDs, tuberculosis, and hepatitis
- Chronic illness, including AIDS, diabetes, congestive heart failure, and asthma
- Mental illness
- Suicidal ideation
- Dental problems
- Organic deficits

A comprehensive health assessment is vital to the offender's well being and thus to a successful transition. If medical problems have been identified, the case manager should ensure continuity of medical care. In many locations, an exoffender is given a 10–15 day supply of prescription medications upon release. The case manager should notify any recipient agency of the offenders' medication needs. As discussed in Chapter 5, the systems working with the offender need complete transfer of medical records. Confidentiality issues must be addressed so that they do not interfere with the receipt of records by the entities that need them. In some situations, the case manager may have to deal with health-related obstacles to treatment. Contagious diseases, for example, may preclude treatment participation.

Once an offender graduates to community supervision, correctional system responsibility for health care usually ceases. Various payment and eligibility options for health care may be available, and the case manager should investigate these options prior to release. Offenders will often need help applying for social security benefits, Medicaid, veterans' entitlements, and any other benefits for which they are eligible. Applications for benefits can be filled out while the offender is still incarcerated; advocacy groups may be of help in this regard. Health education is a key service for special and general populations alike. This education should be conducted both during incarceration and after release.

Substance use disorder treatment should be holistic, taking into account all aspects of a client's life. Nowhere is this more important than with offenders undergoing the drastic change of release from incarceration. This population will confront more triggers for use relapse than most people as they try to learn how to live "on the outside" with the stigma of being criminals. Without such basic supports as housing, employment, and health care, offenders have reduced chances of becoming substance-free.

Quality, comprehensive health services in the correctional setting form the foundation upon which to build solid specialized treatment programs. Voluntary accreditation programs such as that offered by the National Commission on Correctional Health Care (NCCHC) provide standards for health services that help ensure that necessary basic health services are being provided to the facility's population.

A comprehensive health and mental health screen is vital to the offender's well being and thus to a successful transition. In correctional health care, a screening is customarily done upon admission. The people administering the intake screening should be properly trained in a manner approved by the institution's health authority. The screening should be followed up by a complete physical exam performed by a State-licensed clinician. The NCCHC writes health system standards for jails, prisons, and juvenile confinement facilities. They require that intake screenings be followed up with comprehensive physical exams within 7 days in prisons or 14 days in jails.

Recommendations for Coordinating Ancillary Community Services

- Various service providers can be convened in a community coalition to promote access to offenders as they make the transition into the community. This kind of effort builds linkages among different service systems and facilitates the job of the case manager or boundary spanner.
- Face-to-face contact is important so that the members of the team can explain what services they have to offer and can exchange phone numbers and specific information about their programs (such as the name of the contact person and how many slots are in the program).
- Networks can be created that link service providers and the legal sanction agency (see the text box on the Criminal Justice Treatment Network Demonstration Program in Chapter 3).
- Direct contracts can be made by the corrections system with community organizations providing formal services, such as residential and outpatient treatment services, job training, and life skills training.
- Increasingly, treatment providers are purchasing housing for offenders re-entering the community. In addition to providing the obvious need for shelter, it provides a positive social setting because the other tenants, also in transition, can give support to one another.
- Conditions of probation and parole can be modified where possible to require participation in ancillary services (e.g. parenting classes, substance use disorder treatment).

6 Special Populations

It is well documented that the most effective substance use disorder treatment is multifaceted and addresses many aspects of the substance user's life. This is particularly true for criminal justice populations, yet treatment providers generally do not match offenders with substance use disorders to services tailored to their needs. Effective care for those with mental and physical health problems, for example, must incorporate the care of these illnesses into the plan for treatment of substance use disorders and criminality. Assessment and treatment efforts must also acknowledge and incorporate the offenders' differences in culture, gender, age, and type of criminal offense.

People with mental and physical health problems constitute a major category of special needs populations. Society's failure to provide appropriate options for them contributes to disproportionately high numbers of these individuals who eventually find themselves under criminal justice supervision—and many of these offenders, particularly the mentally ill, cycle through the criminal justice and social services systems repeatedly because their problems are not fully addressed in any system. For example, once individuals with mental illness are incarcerated, short-term goals of controlling undesirable behavior and a reliance on medication often take precedence over more comprehensive approaches to treatment.

Upon release, offenders with multiple problems suffer from an additional stigma and may be denied services because community providers lack training to deal with their problems. For example, providers who do not understand the issues for those with mental illness or mental retardation may believe that these individuals cannot benefit from treatment and are dangerous. Part of the case manager's job is to add to the transition team those specialists who can correct such misinformation.

However a population is defined (e.g., by a health problem or cultural background), it is important to know the substances of choice, types of crime, and other life patterns. Elderly people, for example, abuse prescription drugs and alcohol, but rarely use illicit drugs. People with mental retardation are often arrested for nuisance offenses and may be manipulated into criminal activities. Women's substance use is often woven into their intimate relationships; many are incarcerated for possession of a drug that their significant others are selling. These substance use patterns have significant implications for treatment.

Cultural sensitivity and cultural competency, important in all treatment, are particularly essential with offender populations, because minorities are notoriously overrepresented in incarcerated settings. For example, 40.5 percent of the prison population is African-American (Department of Justice, 1998), even though African Americans make up only 12.7 percent of the general U.S. population according to September 1998 census data (U.S. Census Bureau, 1998). For some offenders, such as those of African-American and Latino heritage, the family and extended family should be specifically included in the transition plan because of the importance those cultures place on family relationships. Self-help models of treatment may need adaptation for different cultures and for women.

Ideally, staffing patterns at all levels of the treatment system should reflect the population served, from clerical staff through executive management. Specific efforts should be made to recruit and maintain such staff members. Licensing, certification, and credentialing should support the use of culturally competent staff, and support continuing education in the knowledge and skills relevant to the population. Staff members should be able to communicate in local languages and dialects, and published materials and consent forms should be available in these languages as well. If this is not possible, staff members should find creative means to compensate for this deficit, although family members, especially children, should never be used as interpreters. Incentives that encourage culturally sensitive client interactions should be woven into the employee performance evaluation system.

Whether the differences are cultural, medical, age-, or gender-related, it is important to remember that offenders are not a homogenous population. This chapter will help community treatment providers and correctional workers deliver effective transitional services to groups with special needs.

Women

In 1997, slightly less than 8 percent of those incarcerated were women—6.4 percent of the prison population and 10.6 percent of the jail population (Bureau of Justice Statistics, 1998), but that percentage is rising. Women are substantially more likely than men to serve time for a drug offense rather than a violent crime.

Compared to men, women are more heavily drug-involved (Drug Use Forecasting, 1997), and are often polydrug and intravenous drug users, though they use less alcohol than men. Women in prisons in 1996 were most likely to be black (46 percent), ages 25–34 (50 percent), unemployed at the time of arrest (53 percent), and never married (45 percent). In State prisons in 1991 more than 75 percent of the women had children; two-thirds had children under the age of 18 (Bureau of Justice Statistics, 1994).

Incarcerated women and women with substance use disorders are more likely to have suffered physical and sexual abuse (Hein and Scheier, 1996; Miller et al., 1993; CSAT, 1998a). Incarcerated women's physical health profiles include a high incidence of HIV/AIDS and other STDs, pregnancy, and certain types of coexisting mental disorders. The most common mental health disorder among female offenders is depression. At the Turning Point Alcohol and Drug Program for women in Oregon, approximately 50 percent were diagnosed with depression (Edens et al., 1997) (see box). Another commonly found disorder is post traumatic stress disorder, not uncommon in victims of physical and sexual abuse. The importance of addressing women's health care in correctional settings is spelled out by the National Commission on Correctional Health Care's (NCCHC) position statement on Women's Health Care in Correctional Settings. In it, NCCHC recommends, among other things, intake procedures that include gynecologic history and nutritional intake, pregnancy tests, tests for STDs, and available counseling for depression, substance use disorders, and other disorders common to incarcerated women (National Commission on Correctional Health Care, 1994).

Until recent years, substance use disorder treatment programs for women have been slow to emerge in correctional institutions and in the

Model Program: The Turning Point Alcohol and Drug Program

The Turning Point Alcohol and Drug Program at the Columbia River Correctional Institution in Oregon is a 50-bed therapeutic community for women housed in a minimum security State prison. Originally designed to provide only substance use disorder treatment, high program dropout rates due to mental health problems led to the integration of mental health services. About 60 percent of the women in the program are dually diagnosed. Of those, approximately 70 percent have been diagnosed with post traumatic stress disorder, 50 percent with depression, and 15 percent with bipolar disorder.

Operated by ASAP Treatment Services, the program is structured in five phases that last from 6 to 15 months during the prerelease period, with an average of 7 to 8 months. Each week, at least 30 hours of treatment and educational services are provided. Group sessions incorporate life skills training, relapse prevention strategies, and substance use disorder education. There are 10 counselors on staff with areas of expertise in assessment, family therapy, mental health counseling, and traditional substance use disorder counseling.

community, and many institutions still have no women-specific treatment services. Those services that are available often evolved from models developed for men.

Incarceration disrupts relationships with children, as well as with a spouse or partner. If a woman is a single parent involved in drugs and criminal behavior, a child protective service agency generally steps in after the arrest to take control and custody of dependent children. A high percentage of mothers have their children permanently removed from their custody as a result of their incarceration. Parental rights for mothers (perceived as chief caretakers) are scrutinized closely by social services and foster care workers. In some jurisdictions, women have been increasingly criminalized for using drugs when pregnant.

Transition Issues

When the transition is made to the outside, problems that were temporarily left behind must again be confronted. Domestic violence was a reality for many female offenders before they were incarcerated, and may well be a risk for them when they return to the community. Probation reports may fail to identify this problem, and substance use disorder staff may not be sensitized to it. Case managers should explore this issue as a critical part of the transition plan, and alert community treatment providers. If an offender has no safe place to go, she can be directed to a women's shelter. Some women may resist going to a shelter, because they fear that their children will be taken from them if they do so. Many shelters accept children, however, and a safe environment is of primary importance.

Women may lack social support for spending time on their treatment needs. Drug-involved significant others can pose a significant barrier to a woman's recovery. Making time for treatment sometimes means putting one's own needs first, which can be difficult if a partner opposes the change, or if a woman is the primary caregiver or supporter responsible for minor children. Economic self-sufficiency is a challenge for those who have never held a traditional job or developed employment skills, especially for those faced with supporting their children and themselves. Educational opportunities and job training may differ in men's and women's facilities; it is essential that women are given an adequate chance to prepare themselves for the return to the community.

Transition Services Needed

As with other populations, women should have an effective and realistic transition plan based on a comprehensive biopsychosocial assessment. The plan should consider obstacles, including child care, economic responsibilities for children, and current or prior abuse that are relevant to women and that could preclude or inhibit successful participation in treatment. When possible, women should be referred to programs designed specifically for women. If this is not available, providers should be encouraged to develop same-sex programming. Case managers and counselors should receive training around women's issues and strategies for working effectively with women. Women need positive role models in treatment, both male and female.

As women have distinct medical needs, it is important to address gynecological and reproductive health issues and to provide HIV/AIDS education and services. Women with depression can be linked with women-specific group programs that use medication in combination with cognitive–behavioral treatment. There are also other specialized mental health groups for women offered both in the institution and on the outside.

Because women so often have principal child care responsibilities, and because those responsibilities can be overwhelming, it is important to help women meet their family obligations as they return to the community. Parenting classes can be of help and quality child care may be essential for some women to make a successful transition.

For many women who have not had their children returned to them upon release, family reunification is an important goal. Case management is essential when dealing with a wide variety of issues and public agencies; legal advocates can be of great help in facilitating this process. Special programs may ease the transition. Hour Children, based in Queens, New York, is an agency providing assistance for mothers and children both before and after release. It has advocates for children who transport a child who is in placement to visit the parent or will intervene on behalf of the mother to assist with parental rights issues.

Women may need more job readiness training and job-seeking assistance than men, because many incarcerated women have little or no legitimate work experience. Before they return to the community, it is important that they be given as much preparation as possible. Although assertiveness training generally addresses a wide range of life situations, it can be of particular help preparing women for job-related challenges.

Peer support for substance-using offenders often includes 12-Step programs. Specialized 12-Step groups exist for women, but some controversy exists regarding the appropriateness of traditional 12-Step groups for this population. Some criticize the requirement that women submit to a "higher power" as disempowering to women, who may need to be more assertive, not less. Kasl has developed an alternative 16-step program for women that downplays Alcoholic Anonymous' concept of powerlessness (Kasl, 1992). Kasl replaced the concept of surrendering with one that emphasizes accepting, affirming, and trusting oneself. The support offered by 12-Step self-help groups, especially those designed specifically for women, can be essential to women during transition and recovery (Covington, 1994).

The *Institutional Substance Use Disorder Program Discharge Summary,* included in Appendix B, is an example of a discharge plan used with incarcerated women in some jurisdictions. It is completed in the last 3-6 months of the sentence and asks questions concerning personal goals in many domains of life. The counseling staff guides the offender as she thinks through issues surrounding abstinence, social plans, and physical and recreational goals. The form also includes space to develop a relapse prevention plan. After release, the parole or probation officer receives the completed form to help with transitional treatment goals. The summary plan is a very useful tool, but only if it is shared by the members of the transition team.

Elderly Offenders

Elderly people are now found in correctional institutions in greater numbers because of mandatory minimum sentencing and longer sentences. These prisoners have more health problems and long-term medical conditions than their younger counterparts. The stress of return to the community can be much greater for elderly offenders, especially if they have been incarcerated for many years and have no family or familiar sources of support. See TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998a) for more on elder-specific substance use disorder treatment.

Transitional Issues

Older people have more chronic health issues and less family and peer support. In addition, they may need help accessing a variety of services and entitlement programs—Medicare, Social Security, or perhaps veterans' benefits. The geriatric population is more likely to need supported living arrangements, such as nursing homes. Time management may be more of an issue than among younger people, in part because the elderly are less likely to be employed. The transition team should include an expert in medication management.

Offenders With Mental Illness

Studies indicate that coexisting substance use disorders and mental health disorders occur in approximately 3 to 11 percent of the prison and jail population (Peters and Hills, 1993). Jails have particularly high rates of coexisting disorders. In 1995, urinalysis at booking indicated that more than half of all arrestees tested positive for illicit drug use; 5 percent had both a substance use disorder and a mental illness (National GAINS Center, 1997). Incarcerated substance users have an especially high rate of *serious* mental illness, as approximately 26 percent have a lifetime history of major depression, bipolar disorders, or schizophrenia (Cote and Hodgins, 1990).

Often, correctional facilities merely stabilize acute conditions or may even overmedicate to control behavioral difficulties. People with mental illness are especially vulnerable to victimization within the corrections system, and often there is little family involvement or other outside support. The coexistence of a substance use disorder and mental illness presents a diagnostic challenge, as substance use disorders can mimic or mask underlying psychiatric conditions. Additionally, these inmates are often reluctant to disclose their substance use history. A recent cross-training curriculum instructs staff in both systems on working with offenders with coexisting mental health disorders (Virginia Addiction Technology Transfer Center, 1996). (See Figure 6-1 for a review of treatment programs for this population).

Transition Issues

Professionals in the corrections or treatment communities sometimes have negative preconceptions about this population. It is difficult for those with coexisting disorders to get parole, because parole board members often have little understanding of these disorders or of current treatment methods, and they are primarily concerned about community safety when considering release. Sometimes inmates refuse medication before an appearance before the parole board so they can truthfully say they are not being psychiatrically medicated.

Transition Services

For many offenders who are mentally ill, maintaining a stable mental health status requires careful monitoring and coordination. An important initial step to support the offender in transition is to verify that medicines and files are transferred. Consistency in treatment and medication is critical, but failures in continuity are common. Neglect of medications and treatment can lead to a downward spiral toward relapse. In some cases, offenders are overmedicated at the time of release to the community, because high doses of medication reduce disciplinary problems in the institution. The transition team, especially the community provider, may be left to deal with issues of disruption in medication or of over-medication.

Case managers should take an active role in ensuring intersystem communication, as the mental health and substance use disorder systems are sometimes separate in prison and usually separate in the community as well. Some substance use programs in the community refuse to treat the mentally ill, while some mental health facilities turn away those with substance use disorder problems. Such actions violate the Americans With Disabilities Act, which prohibits substance use disorder programs from turning away people with other disabilities and social service programs from refusing people with substance use disorder problems. Philosophical approaches to treatment—for example, medical model versus self-help model—may divide providers and interfere with treatment. All parties treating this group of offenders should come to agreement on a treatment approach and common terminology. Mistrust of the other system and exclusionary policies should be addressed and minimized.

Lack of insurance (or underinsurance) creates the potential for discontinuity of treatment following placement in the community. Corrections agencies may discontinue mental health services once the offender is released. Every effort must be made to identify funding for mental health treatment. Greater duration and intensity of treatment improves outcomes, but may run counter to current managed care strategies of reducing length of treatment. In the current environment of managed care, advocacy for this population is essential.

Services necessary for a successful transition for those with coexisting disorders also include

- Assertive outreach by the case manager to engage the offender in services
- Comprehensive assessments of both substance use disorders and other mental disorders followed by treatment plans designed to monitor and continue to identify these disorders
- Tracking through the criminal justice system and into the community
- Cross-training of substance use disorder and mental health staff and community correction/security staff about both types of disorders
- A transition plan that takes into account mental illness as well as substance use in relapse prevention efforts
- A sufficient supply of medication and careful medication planning that is coordinated among the offender and staff from all systems (i.e., criminal justice, mental health, substance use disorder)

Figure 6-1
A Review of Treatment Programs for Offenders With Coexisting Disorders

A recent review of treatment programs for prison inmates with coexisting disorders (Edens et al., 1997) brings attention to efforts currently under way to meet the needs of those with coexisting disorders in prisons. The authors identified seven programs that provide specialized services for this population. Most of these initiatives evolved from the recognition that this population does not respond well to traditional intervention methods.

Transitional or aftercare services in these programs generally begin with placement in a halfway house or other transitional setting, such as work release. Transportation to the aftercare facilities is usually coordinated by the programs. The Turning Point program (see box on page 75) contracts with several aftercare programs and provides funds for 2 months of treatment after release. The Substance Abuse Felony Punishment Facilities (TDCJ Estelle II and Hackberry Units) in Texas provide coordination and funding of transitional services through State agencies.

Several programs employ transitional coordinators, who work with case managers to provide linkages to community resources prior to release. In some programs, these coordinators also develop a plan for services and arrange meetings between the offender and the assigned case manager. All programs described in the review provide parole/supervision officers with an aftercare plan for those inmates who are released to community supervision programs.

The common goals of these prison programs, consistent with treatment approaches for those with coexisting disorders in community settings, are

- The use of staff with training in mental health issues as well as substance use disorders
- Consideration of both disorders as primary
- Individualized assessments of skill deficits and symptom severity
- Use of medication (when necessary)
- A long-term treatment focus with an emphasis on phases of treatment
- Appreciation of the integral role of self-help treatment
- Recognition that treatment must extend beyond the institution and into the community

The authors found significant gaps in service during the transition period because of the expected difficulties in providing a comprehensive range of services for this population. These included a lack of transitional housing options for those in rural settings, a lack of availability or access to mental health services, resistance by community agencies to providing services to offenders, a lack of mental health services and medication monitoring in community programs, lack of cross-training in mental health issues for community supervision officers, and offender resistance to treatment after release.

- The provision of structured daily activities, as those with mental illness may need that structure
- Practical help with everyday tasks—such as filling out forms to guarantee eligibility for Federal programs (e.g., Medicaid, Social Security disability benefits)
- Preparation of offenders for involvement in 12-Step groups, as many self-help groups won't accept those on medication (specialty groups such as Double Trouble that offer support to those with coexisting disorders should be sought)

- Substance use disorder and mental health treatment that is provided by a multidisciplinary staff

Offenders With Mental Retardation

The term "mental retardation" describes developmental disabilities that range from moderate to very severe. In prisons, most inmates who are mentally retarded have compromised intellectual functioning but are not profoundly retarded. Individuals with more severe disabilities are usually housed in specialized State facilities separate from the criminal justice population. Those with borderline IQs often are not eligible for services from State mental retardation agencies and end up in the criminal justice system.

A key issue for the mentally retarded in incarcerated settings is their vulnerability. Correctional officers may unwittingly give such inmates directives they don't understand and berate the inmate for disobeying. Because inmates with mental retardation may have poor judgment, they are easily exploited or manipulated by other inmates. For example, they are often used in drug trafficking—and more likely to be caught—because of their naivete.

Transition Services Needed

An assessment of intellectual level should be provided by the correctional facility prior to the offender's return to the community. It is important to have experts in mental retardation involved in the transition. Qualified individuals who can participate in the transition team can often be found in area schools that receive funding for special education. Advocacy groups that promote the interests of persons with mental retardation can also be of substantial help. Finally, high functioning exoffenders with mental retardation can perform a valuable mentoring role.

Illiteracy is an issue for many offenders with mental retardation, and treatment efforts must be geared toward the appropriate level of comprehension. Help may be needed in basic areas such as dressing appropriately, maintaining proper hygiene, planning nutritious meals, and completing paperwork and forms that will be required in the community.

Additional research and training curricula for treatment and criminal justice staff are needed on the best methods for managing and treating individuals with both substance use disorders and mental retardation. One helpful curriculum was developed at the State University of New York at Buffalo (Posluszny et al., 1996).

Sex Offenders

Because sex offenders have often served long sentences, they may experience significant difficulties during transition because of the impact of institutionalization.

Treatment aimed at diminishing the impulse to commit sex offenses generally does not also incorporate comprehensive substance use disorder treatment components for sex offenders with substance use disorder histories. Sex offenders are often barred from substance use disorder treatment both while incarcerated and in the community. When they do receive treatment, it is common for sex offenders to overreport their substance use so they can claim that their sex offenses were caused by problems with substances. They may want to enroll in treatment programs to impress a parole board rather than out of a genuine desire for abstinence.

Generally, it is useful to address the sex offender's behavior prior to focusing on substance use issues. However, treatment must take into account both problems. As the relationship between substance use disorder and violent offenses is complex, it is important that the treatment providers who work with this population have a sophisticated understanding of the issues. As many States are now eliminating programs for sex offenders, the substance use disorder treatment community may become the first line of treatment for many of these individuals, which highlights the field's need for an in-depth understanding of this population.

Long-Term Medical Conditions

Inmates often have chronic and contagious medical conditions, so it is crucial to prevent prisons from becoming incubators for disease. The fact that there can be long periods before a disease is diagnosed makes the spread of disease more likely. Implementing universal precautions against blood contamination is in the interest of public health. Given the high numbers of intravenous drug users in the criminal justice population, and the occurrence of unprotected sex in prisons, the risk of spreading HIV is substantial. Adding to that risk, inmates who are aware that they are HIV-positive may not want to disclose this information. Tuberculosis, other airborne diseases, and hepatitis also flourish in the institutional setting. Hepatitis C, which is becoming more common, is not currently treatable with antibiotics.

Health services accreditation programs such as that offered by the National Commission on Correctional Health Care (NCCHC) disseminate standards that address these concerns. In facilities that meet those standards, the health services program functions as a "public health department" for a prison community.

Women often have long-term health problems, and many have engaged in prostitution or other risky behaviors. Female prisoners' rate of infection with HIV has been increasing. This trend may reduce access to general substance use disorder programs, either because the infectious condition is used to exclude these individuals, or because their medical needs cannot be met within the substance use disorder treatment program.

In addition to preventing the acquisition of new health problems in prison, it is necessary to ensure that preexisting conditions are adequately treated. For example, those with HIV should be treated with an appropriate drug regimen to prevent full-blown AIDS from developing. Prisoners needing dialysis or other medical services must have access to competent and sufficiently frequent care.

Transition Services Needed

If offenders have had their medical needs addressed in prison, it will help facilitate a smooth transition back to the community. It is critical that there are no gaps in treatment or the receipt of medications. The treatment schedule established in the institution should continue on the outside without interruption.

Medical problems can be potent relapse triggers, and depression can lead to renewed substance use disorders. Resumption of substance use can harm the immune system, aggravating physical problems. Community providers should be aware of the mental health risks associated with particular diseases and work to forestall difficulties.

The Panel recommends the mainstreaming of those with HIV into community treatment groups. HIV and other support groups within the community, however, can enhance the effectiveness of substance use disorder treatment. TIP 15, *Treatment for HIV-Infected Alcohol and Other Drug Abusers,* describes the linkages and social service needs for those with substance use disorder problems and HIV (CSAT, 1995). Legal issues, such as confidentiality considerations, are also discussed in detail in TIP 15, which will be revised in 1999.

Offenders With Physical Disabilities

Physical disabilities take many forms. Some impede mobility; others limit sensory or expressive capacity. The Americans With Disabilities Act (ADA), 42 U.S.C; Chapter 126, requires that State and some private facilities be accessible and that programs accommodate those with disabilities. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C., Chapter 16, governs all Federal programs and facilities. Reasonable efforts must be made to enhance or modify substance use disorder treatment. Solutions go beyond merely removing architectural barriers. For example, blind prisoners can be given treatment materials either in Braille or on tape. Sign language interpreters may be necessary for hearing impaired prisoners. Thoughtful logistical planning is imperative in meeting the needs of this population.

Transition Services Needed

A balance must be struck between providing special services for offenders with physical disorders and mainstreaming. Sometimes special units will be necessary; in other instances, minor modifications can allow these individuals to participate in programs with the general population.

A screening for disabilities, including traumatic brain injury or certain physical conditions, should be conducted at intake into the correctional system. When the offender returns to the community, all relevant medical information should be transmitted to the appropriate parties. If medication is used to treat the disability, it is important that there is no gap in its use.

Many advocacy groups safeguard and promote the interests of disabled persons. During the transition period, contact with representatives of these groups may be helpful. For more information on this topic, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT, 1998).

Appendix A

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Appendix B
Instruments

This appendix includes

- The Substance Use Survey (SUS)
- Adolescent Self Assessment Profile (ASAP)
- Institutional Substance Use Disorder Program Discharge Summary
- Transition Plan from the Powder River Alcohol and Drug Program
- Contacts Directory

Substance Use Survey (SUS)

SUBSTANCE USE SURVEY (SUS) - IA

Kenneth W. Wanberg
Author

I.D. No. ____________
Program No. ________

DESCRIPTIVE INFORMATION

NAME________________________ CLINICIAN______________ CATCHMENT AREA________

DATE__________ AGE_____ GENDER: ☐ Male ☐ Female YEARS OF SCHOOLING ______

ETHNICITY: ☐ Anglo ☐ Black ☐ Hispanic ☐ Native American ☐ Other

INFORMATION AND INSTRUCTIONS ON THE USE OF THIS SURVEY

This booklet contains questions about how you see yourself. Some questions have to do with your feelings and emotions and others have to do with the use of alcohol and drugs. The information you provide will be treated as strictly confidential and will only be used by your counselors. Be as honest as you can. This will help those who are working with you to understand your concerns and questions about yourself and about your use of alcohol and other drugs. For each question in this survey, circle the letter under the answer that best fits you. **NOW YOU MAY TURN THE PAGE AND BEGIN TO ANSWER THE QUESTIONS.**

SUMMARY OF SUBSTANCE USE SURVEY (FOR STAFF USE ONLY)

1. Degree of involvement in the use of alcohol and other drugs?

Minimal		Low			Moderate			High	
0	1	2	3	4	5	6	7	8	9

2. Degree of disruption of life functioning due to the use of alcohol or other drugs?

Minimal		Low			Moderate			High	
0	1	2	3	4	5	6	7	8	9

3. Degree of mental health problems?

Minimal		Low			Moderate			High	
0	1	2	3	4	5	6	7	8	9

4. Degree of motivation for counseling or other help?

Minimal		Low			Moderate			High	
0	1	2	3	4	5	6	7	8	9

5. Level of recommended drug/alcohol services?
   - ☐ Prevention
   - ☐ Intervention
   - ☐ Treatment

6. Level of intensity of drug/alcohol services?
   - ☐ Low
   - ☐ Moderate
   - ☐ High

7. Method of Administering SUS-IA?
   - ☐ Face-to-face interview
   - ☐ Self-administered
   - ☐ Group
   - ☐ Computer

SUS Profile Summary IA

SCALE NAME	RAW SCORE	Low			Low-medium		High-medium		High			NUMBER IN NORM SAMPLE*
		DECILE RANK										
		1	2	3	4	5	6	7	8	9	10	
1. INVOLVEMENT		0 1	2	3	4 5	6 7	8 9	10 11	12 13 15	16 18 20	21 26 50	371
2. DISRUPTION		0	1	2 3	4 5	6 7 8	9 10 11	12 14 17	18 21 24	25 30 39	40 48 77	371
3. PSYCHOLOGICAL		0 1	2	3	4	5	6	7 8	9 10	11 12	13 15 25	371
4. OADS		0 5 6	7 8 9 10	11 12	13 15 17	18 20 22	23 26 29	30 34 37	38 44 50	51 56 68	69 142	371
5. SUSR		0 1 2	3 4	5	6 7	8	9 10	11	12 13	14	15 16 18	371

1 10 20 30 40 50 60 70 80 90 99
PERCENTILE

*Juvenile Justice Group

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Below are different kinds of drugs that people have had a chance to use or that people do use. For each of the following drugs, circle the letter under the answer that best fits you. Also, if you did use the drug, write down how old you were when you first used the the drug and also check the last column if you used the drug within the past three months.

	Never had a chance to use	Had a chance but did not use	Number of cigarettes a day				Age you first smoked	Smoked in past month
Name of drug			**1-5 a day**	**6-10 a day**	**11-20 a day**	**More 21 a day**		
1. Cigarettes (tobacco)	a	b	c	d	e	f	____	____

	Never had chance to use	Had a chance but did not use	Used 1-10 times	Used 11-25 times	Used 26-50 times	Used more than 50 times	Age first used	Used in last three months
2. Beer	a	b	c	d	e	f	____	____
3. Wine or wine coolers	a	b	c	d	e	f	____	____
4. Hard liquor (whiskey, gin, etc)	a	b	c	d	e	f	____	____
5. Marijuana (pot, weed, joint, hash, THC)	a	b	c	d	e	f	____	____
6. Cocaine (coke, crack, rock)	a	b	c	d	e	f	____	____
7. Amphetamines (speed, black beauties, ice, uppers, crystal)	a	b	c	d	e	f	____	____
8. Acid (LSD)	a	b	c	d	e	f	____	____
9. Mushrooms (shrooms)	a	b	c	d	e	f	____	____
10. PCP (angel dust)	a	b	c	d	e	f	____	____
11. Huffed or sniffed glue	a	b	c	d	e	f	____	____
12. Huffed gasoline	a	b	c	d	e	f	____	____
13. Huffed paint	a	b	c	d	e	f	____	____
14. Huffed white out	a	b	c	d	e	f	____	____
15. Sniffed rush (amyl nitrate, poppers)	a	b	c	d	e	f	____	____
16. Heroin (horse, junk, smack)	a	b	c	d	e	f	____	____
17. Opium	a	b	c	d	e	f	____	____
18. Pain killers (morphine, Percodan)	a	b	c	d	e	f	____	____
19. Barbiturates/sedatives (reds, blues, yellows, quaaludes, Dalmane, seconal, sleeping pills)	a	b	c	d	e	f	____	____
20. Tranquilizers (valium, Librium, Atavan, Serax, Miltown, Equanil, meprobamates)	a	b	c	d	e	f	____	____
	____	____	____	____	____	____		☐

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As a result of using or coming off of any of the above drugs (including alcohol), how often have any of the following happened to you? Circle the letter under the answer that best fits you. If you have never used drugs, then skip questions 21 through 41 and start again with question 42.

		Never	**1 - 3 times**	**4 - 6 times**	**7 - 10 times**	**More than 10 times**
21.	Had a blackout (forgot what you did but were still awake)?	a	b	c	d	e
22.	Passed out (became unconscious)?	a	b	c	d	e
23.	Tried to take your life?	a	b	c	d	e
24.	Became physically violent?	a	b	c	d	e
25.	Became sick to your stomach?	a	b	c	d	e
26.	Had physical shakes or tremors?	a	b	c	d	e
27.	Unable to go to school or work	a	b	c	d	e
28.	Broke the law or committed a crime?	a	b	c	d	e
29.	Caused problems with your family?	a	b	c	d	e
30.	Lost interest in things?	a	b	c	d	e
31.	Stole goods or money in order to buy drugs or alcohol?	a	b	c	d	e
32.	Felt guilty and felt bad?	a	b	c	d	e
33.	Became very upset and emotional?	a	b	c	d	e
34.	Saw or heard things not there?	a	b	c	d	e
35.	Had a fast or rapid heart beat?	a	b	c	d	e
36.	Became very nervous and tense?	a	b	c	d	e
37.	Felt sad and cried?	a	b	c	d	e
38.	Felt feverish, hot or sweaty?	a	b	c	d	e
39.	Did not eat or sleep?	a	b	c	d	e
40.	Felt tired and weak?	a	b	c	d	e
41.	Felt rejected by friends?	a	b	c	d	e
		___	___	___	___	___

☐

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For each of the following questions, please circle the letter under the answer for each question which best fits you.

		No	**Sometimes**	**Usually**	**All the time**
42.	Have felt nervous or tense (uptight).	a	b	c	d
43.	Have felt down or depressed?	a	b	c	d
44.	Have worried a lot about things?	a	b	c	d
45.	Have felt upset?	a	b	c	d
46.	Have gotten angry and lost my temper?	a	b	c	d
47.	Haven't gotten along with people?	a	b	c	d
48.	Have felt mixed up or confused?	a	b	c	d
49.	Have seen or heard things not there when not on drugs?	a	b	c	d

		No	**Once**	**Twice**	**More than two times**
50.	Have you had thoughts about not wanting to live (committing suicide)?	a	b	c	d
51.	Have you tried to take your life?	a	b	c	d
52.	Have you had help for emotional or mental health problems?	a	b	c	d
53.	Have you had help for drug or alcohol problems?	a	b	c	d
54.	Have you injected drugs (use a needle to take drugs)?	a	b	c	d

		No	**A few times**	**A lot of times**	**All the time**
55.	Have you ever been part of a gang or involved in gang activities?	a	b	c	d
56.	Have you ever been involved in selling or dealing drugs?	a	b	c	d

		No never	**One or two times**	**Quite a few times**	**Many times**
57.	Have you gotten angry with someone?	a	b	c	d
58.	Have you ever been unhappy?	a	b	c	d
59.	Have you broken the law?	a	b	c	d
60.	Have you ever cried or felt sad?	a	b	c	d
61.	Have you ever told a lie or not told the truth?	a	b	c	d

		For sure no	**Maybe no**	**Maybe yes**	**For sure yes**
62.	Do you **want** to stop using (or not use) alcohol?	a	b	c	d
63.	Do you **want** to stop using (or not use) drugs other than alcohol?	a	b	c	d
64.	Do you **plan** to stop using alcohol?	a	b	c	d
65.	Do you **plan** to stop using drugs other than alcohol?	a	b	c	d
66.	Do you need help with an alcohol problem or other drug use problem?	a	b	c	d
67.	Would you be willing to come to a program where people get help for drug and alcohol problems?	a	b	c	d ☐

END OF SURVEY. THANK YOU.

Adolescent Self Assessment Profile (ASAP)

ADOLESCENT SELF ASSESSMENT PROFILE (ASAP)
K. W. Wanberg, Author

DACOD ______________________

AGENCY CLIENT I.D. ______________

AGENCY NAME OR I.D. ______________

TO BE COMPLETED BY CLIENT

NAME ______________________ DATE __________ BIRTH DATE __________ YOUR AGE ____

YOUR GENDER: ☐ FEMALE ☐ MALE ____ YEARS OF SCHOOLING YOU COMPLETED ________

YOUR ETHNIC GROUP: ☐ Anglo ☐ American Indian ☐ Asian
☐ Black ☐ Hispanic

HOW YOU TOOK ASAP: ☐ Interview with staff ☐ By yourself ☐ In a group
☐ On a computer

NOW ATTENDING SCHOOL: ☐ No ☐ Yes DO YOU NOW HAVE A JOB: ☐ No ☐ Yes

PLEASE READ THE INSTRUCTIONS IN THE TEST BOOKLET BEFORE YOU ANSWER THE QUESTIONS. YOU ARE ASKED TO MARK YOUR ANSWERS ON THE FOLLOWING PAGES OF THIS ANSWER BOOKLET.

TO BE COMPLETED BY STAFF WHO ADMINISTERED ASAP

A. Ratings of Client by Staff

1. Family disruption.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

2. Mental health problems.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

3. Peer influence.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

4. School problems.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

5. Deviant behaviors.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

6. Involvement in alcohol or other drug use.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

7. Disruption due to alcohol/other drug use.

Minimal Low Moderate Severe
0 1 2 3 4 5 6 7 8 9

B. Drug and Alcohol Services

☐ Prevention
☐ Intervention
☐ Treatment

C. Current Treatment Setting

☐ Outpatient (traditional)
☐ Outpatient (intensive)
☐ Day care
☐ Detoxification
☐ Residential

D. Referral Source (Check only one)

☐ Self
☐ Parent or family member
☐ School
☐ Professional
☐ Probation only
☐ TASC probation
☐ TASC only
☐ Direct from court
☐ Division of Youth Services
☐ Social services
☐ Human service professional
☐ Medical professional
☐ Other ______________

E. Admission Status

☐ Voluntary
☐ Court order

F. Motivation

Low Moderate High
0 1 2 3 4 5 6 7

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Sample Substance Use Disorder Program Discharge Summary

DISCHARGE SUMMARY

Name ______________________ SID # ____________ TDCJ # ____________

Date of Entry ______________________ Scheduled Release Date ____________

County of Conviction ______________________ County of Residence ____________

Primary Counselor ______________________

Transitional Coordinator/Case Manager ______________________

Circumstances of Discharge ______________________

Identified needs and problems (from Master Treatment Plan):

Progress and Prognosis:

Resident ______________________ Date ____________

Primary Counselor ______________________ Date ____________

Transitional Coordinator/Case Manager ______________________ Date ____________

Senior Counselor ______________________ Date ____________

What are you going to do if a relapse occurs?

What type of support group(s) will you attend and where?

Will you have a sponsor? Who? Why that person?

Are you going to work the 12 steps?

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How are you going to use your leisure time?

PERSONAL AFTERCARE GOALS AND OBJECTIVES

ABSTINENCE GOALS: What do I need to maintain my sobriety? (Basic Needs)

What do I need in order to continue to grow and strengthen my sobriety?

SOCIAL GOALS: What type of relationships with others do I need in order to feel I have a healthy social life that will enhance positive feelings about myself and my sobriety?

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PHYSICAL GOALS: What are my specific plans for increasing my physical health?

What type of maintenance schedule will I need in order to continue the changes initiated during my treatment?

RECREATIONAL GOALS: What do I plan to do to meet my needs for fun and frolic that will not endanger my sobriety?

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CREATIVE AND OTHER PERSONAL GOALS: In what areas am I creatively talented?

What are some specific projects I want to begin and complete after discharge (e.g., music, art, carpentry, auto mechanics, writing, and electronics)?

What are the steps I need to take in order to successfully initiate and complete a creative project?

NOTES/COMMENTS:

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Need	No.	Recommendations
Substance Use		
Self Help Group		
Housing		
Educational		
Vocational		
Employment		
Psychological		
Medical/Dental		
Legal		
Other		

Educational/Vocational Programs Completed (Dates) During Confinement	Proposed Residence Address and Relationship	Proposed Employment

Staff comments

Resident

Primary Counselor

Date

Date

Transitional Coordinator/Case Manager

Distribution:
- ○ Treatment
- ○ Parole Officer
- ○ Transitional Coordinator/Case Manager
- ○ PD Case Manager

RELAPSE PREVENTION PLAN

1. Prepare list of personal early warning signs.
2. Develop new responses to those signs.
3. Prepare list of events and high risk situations.
4. Develop list of significant others that are helpful in a relapse situation.

PREPARE AN EMERGENCY PLAN

Call Someone:

Go Somewhere:

Keep an emergency plan in a convenient place with enough money for telephone calls, taxi fare, gasoline money, etc.

Remember that relapse is a process and not an event. The earlier that you interrupt the process, the more likely you are to be successful.

STRESSORS:

Powder River Transition Plan

Transition Team Checklist Resident Chart

Name: ______________________________ CPMS #: ____________

Admission Date: ____________ SID #: ____________

Release Date: ____________

Certificates:

_____ Attendance _____ Justification Form _____ Chart Copy
_____ Participation _____ Justification Form _____ Chart Copy
_____ Graduation _____ Justification Form _____ Chart Copy

_____ Comprehensive Continuing Care Plan

Releases:

_____ Family
_____ Medical
_____ DOC
_____ Continuing Care Provider
_____ Parole Officer
_____ (Other)
_____ Media
_____ Continuing Developing Recovery Plans
_____ Warning Sign Identification Card / When I experience this warning sign
_____ Relapse Prevention Plan
_____ Post Test
_____ Criminal First Step
_____ Other ___________ Mandatory Electives
_____ Step Work 1 2 3 4 5 / 6 7 8

Tele-conference Calls:

_____ Family
_____ Parole Officer
_____ Continuing Care Provider
_____ Employer
_____ Other

Transfer Summaries:

_____ Assessment
_____ Treatment

Discharge Summary:

_____ Transition
_____ CPMS Termination Form
_____ Chart Closure

Comprehensive Continuing Care Plan

POWDER RIVER CORRECTIONAL
ALCOHOL & DRUG TREATMENT UNIT
3600 13TH Street
Baker City, OR 97814

Phone: (541) 523-9894
Fax: (541) 523-8067

Client: ______
Address: ______
City: ______
St/Zip: ______
Phone: (_____) ______

SID#: ______ DOB: ______
CPMS#: ______ Admit Date: ______
Cnty. Of Conv.: ______ Release Date: ______
Treatment Level: ______ Steps Completed: ______
Cert.: ☐ Attendance ☐ Graduation Date: ______

Employment ______
Contact: ______
Address: ______
City: ______
St/Zip: ______
Phone: (_____) ______

C/C Provider: ______
Contact Name: ______
Address: ______
City: ______
St/Zip: ______
Phone: (_____) ______

Date: ______ Time: ______
No. of Weeks ______ Times per week ______

Support System: AA / NA / ______
Date: ______ Time: ______
No. of Weeks ______ Times per week ______
Meeting Address: ______

Sponsor/Contact: ______
Address: ______
City: ______
St/Zip: ______
Phone: (_____) ______

______ ______
(Resident signature) (Date)

cc:
Resident ______ Primary ______
P/PO ______ A/C ______

P/PO: ______
Contact Name: ______
Address: ______
City: ______
St/Zip: ______
Phone: (_____) ______

Date: ______ Time: ______
No. of Weeks ______ Times per week ______

Parole Stipulations: ______

Additional Type of Service: ______
Contact Name: ______
Address: ______
City: ______
St/Zip: ______
Phone: (_____) ______

Date: ______ Time: ______
No. of Weeks ______ Times per week ______

C/C/C Package Completed: ______

______ ______
(Primary's signature) (Date)

File ______ DOC ______
Admin. ______ Other ______

Relapse Prevention Plan

A. List the behaviors you show as warning signs as you are moving closer to using alcohol or drugs:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

B. List the most effective actions you can take when these signs occur:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

C. People who know your warning signs, and who will strongly suggest actions you can take to intervene in your relapse:

1. ______________________________
2. ______________________________
3. ______________________________

____
(Resident's Signature) (Date)

____
(Counselor's Signature) (Date)

Personal Continuing Care Plan

The quality of my sobriety will depend on how willing I am to put forth effort in the following areas:

PHYSICAL RECOVERY, PSYCHOLOGICAL RECOVERY, RELAPSE PREVENTION, SUPPORT RESOURCES, SOCIAL RECOVERY, LEISURE TIME ACTIVITIES, STRESS MANAGEMENT, and CRIMINAL THINKING ERRORS and PATTERNS.

Of course I need to break each of these areas down into something I can understand and FOLLOW.

For my **PHYSICAL RECOVERY** I must plan what I am going to do about:

My Nutrition:

Caffeine and Sugar:

Vitamins:

My Exercise Plan:

Sleep:

Personal Continuing Care Plan

For my **PSYCHOLOGICAL RECOVERY** I need to learn to cope with emotions, especially negative feelings like anger, fear, guilt, etc.

This is what happens to me when I have these negative feelings:

Physically:

Emotionally:

My most difficult feeling to express or cope with is:

These are the ways I can deal with these feelings:

My second most-hard-to-handle feeling is:

These are the ways I can deal with these feelings:

Personal Continuing Care Plan (continued)

RELAPSE PREVENTION is the next area I must take a look at and the 37 relapse warning signs.

After studying that list, I know that my 5 most important relapse warning signs are:

(1) ______________________ (2) ____________________ (3) ____________________
(4) ______________________ (5) ____________________

In my own words I describe them as:
(1)____
(2)____
(3)____
(4)____
(5)____

When I recognize these danger signs, this is the way I plan to handle them (unlike how I did in the past).
(1)____
(2)____
(3)____
(4)____
(5)____

I know I am going to need **SUPPORT RESOURCES**.

My support system is:
____
____
____
____
____
____
____

Personal Continuing Care Plan (continued)

My **SOCIAL RECOVERY** is probably going to be one of the most difficult things I have to do. My friends have been a big part of my life and I need to "fit in" somewhere. I have to reevaluate many relationships. I have to ask myself some important questions.

Are there people I need to avoid? ______________________

If so, who?

____

____

____

____

____

Where can I meet new "healthy" people?

____

____

____

____

____

Are there situations or places I need to avoid?

____

____

____

____

____

Will I allow myself to be put in places where there are alcohol or drugs?______________

____

Why or why not?

____

____

What will I do if someone brings alcohol or drugs into my house?

____

____

____

Personal Continuing Care Plan (continued)

My **LEISURE TIME ACTIVITIES** are:

How often do I want to do these activities?

What new areas of recreational activities will I start in the next 6 months?

How important is it for me to enjoy myself and my amily?

(EXPLAIN)

It is extremely important to me to understand and learn **STRESS MANAGEMENT**. Looking back, I have already covered many topics in this plan. Which of these areas are stress management techniques? (Example—Physical Recovery, etc.)

What other stress management techniques will I use?

Personal Continuing Care Plan (continued)

What are my most pronounced **CRIMINAL THINKING ERRORS** ?

What are my most pronounced **CRIMINAL THINKING PATTERNS** ?

CRIMINAL RELAPSE PREVENTION is another area I must take a look at. I know that my five most important criminal relapse warning signs are:

(1) ____________________ (2) ____________________
(3) ____________________ (4) ____________________
(5) ____________________

When I recognize these criminal relapse danger signs, this is the way I plan to handle them (unlike how I did in the past):

(1)____
(2)____
(3)____
(4)____
(5)____

Looking back, what progress have I made while in treatment?

GOD,

GRANT ME THE SERENITY TO ACCEPT THE THINGS I CAN NOT CHANGE, TO CHANGE THE THINGS I CAN, AND THE WISDOM TO KNOW THE DIFFERENCE.

Transition Treatment Action Plan

Resident Name: ______________________ **Date:** ____________

I. PROBLEM #: VII SECTION #: A Special Needs WEEK 1-2
A.2. Case Management Plan

II. OBJECTIVE (must be timely/ measurable/ behavioral):

Within the next (   ) days, I will be able to complete a continuing care plan. The goal of this plan is to assist me to NOT return to alcohol and drug use or criminality.

III. PLAN OF ACTION (based on direct alterations of behaviors or of obstacles to change, frequency):

Target Date ____________	Actual Date ____________	Staff/Res. Initials ____________

1. Complete Comprehensive Continuing Care Plan (with Primary)____________
____________Give to Secretary for processing by:____________

2. Sign appropriate release of information (with Primary)____________

Prepare Relapse Prevention Plan__________Turn in to Primary by:____________
____________Read in group by____________
____________Original to file by:____________

Obtain Release Prevention/ Transition Packet____________

RESIDENT SIGNATURE ____________ **DATE:** ____________

STAFF SIGNATURE ____________ **DATE:** ____________

Contacts Directory

Phoenix House

PO Box 33
Utica, NY
Contact: J. Smith

Denver Juvenile Justice Integrated Network

303 West Colfax Avenue, #975
Denver, CO 80204
(303) 893-6898.
Jennifer Mankey, Project Director

Family and Corrections Network

32 Oak Grove Rd.,
Palmyra, VA 22963
(804) 589-3036; fax (804) 589-6520

Center for Sex Offender Management (CSOM)

8403 Colesville Road, Suite 720
Silver Spring, MD 20910
(301) 589-9383; fax (301) 589-3505

A collaborative effort of the Office of Justice Programs, the National Institute for Corrections, and the State Justice Institute, CSOM provides a clearinghouse for issues related to sex offender programs.

Substance Use Survey (SUS) – IA

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Center for Addictions Research and Evaluation
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Arcada, CO 80002
(303) 421-1261

Adolescent Self Assessment Profile (ASAP)

Ken Wanberg, Th.D., Ph.D.
Center for Addictions Research and Evaluation
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Arvada, CO 80002
(303) 421-1261

Appendix C
Resource Panel

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Public Health Advisor
Treatment Operations and Review
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Center for Substance Abuse Treatment
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Patrick Coleman
Resident Practitioner
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Joseph Cronk
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Oxford House, Inc.
Silver Spring, Maryland

Marc Pearce
Chief of Staff
National Association of Drug Court Professionals
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Steven J. Shapiro
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National Commission on Correctional Health Care
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Rodney D. Stewart
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Youth Facility
D.C. Department of Corrections
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Department of Veterans Affairs
Mental Health and Behavioral Sciences Services
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Laura A. Winterfield, Ph.D.
Social Science Analyst
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Department of Justice
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Appendix D
Field Reviewers

David M. Altschuler, Ph.D.
Principal Research Scientist
Insitute for Policy Studies
Johns Hopkins University
Baltimore, Maryland

G. Dean Austin, M.A., Ed.
Bureau Chief
Bureau of Licensure and Support Services
Iowa Department of Public Health
Des Moines, Iowa

Donna H. Caum, M.S.S.W.
Treatment Program Consultant
Bureau of Alcohol and Drug Abuse Services
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